Session Summaries

Session 102

(When things don't go according to) Plan Administration

Speakers:

- Joseph S. Adams – Winston & Strawn LLP
- Meryl Feigenbaum, FCA, ASA, EA, MAAA – Gallagher
- Peter Neuwirth FCA, FSA – CapAcuity / Neuwirth Associates

Session Host: Hilja Viidemann, FCA, FSA, EA, MAAA – Gallagher

Overview

Plan administration is complex, and difficult situations often arise due to long, complicated plan histories and missing/incomplete participant records. Panelists discussed issues to look out for and offered practical approaches to address some of these issues.

Correction Methods to avoid plan disqualification

The IRS Employee Plans Compliance Resolution System (EPCRS) Program allows three methods of correcting issues. All three methods have been available for some time, and Secure 2.0 has made some changes to the scope and availability of these programs.

Self-correction Program (SCP) requires no fee, but the plan administrator must have demonstrated procedures to use it. A plan document alone is not enough, and a determination letter may be needed. Insignificant details can be corrected indefinitely under this program, and more significant details can be corrected within three years. What is "significant" depends on (1) how many participants were affected (2) for how many years (3) how many dollars. Examples of what can be corrected are participant loan issues and late enrollments. The plan sponsor should keep records of the corrections in case they are audited by the IRS. Secure 2.0 expanded the scope of this program and set up a new very broad term, "eligible inadvertent failure". A defect that falls under this category can go back indefinitely and must be corrected within 18 months of finding it.

Under Secure 2.0, the plan sponsor does not have to recoup overpayments from participants and put in details related to overpayments that are favorable to participants: if the plan sponsor chooses to recoup payments made in error, the payback cannot be more than 10% of the current payment, and the plan sponsor cannot charge interest. If the overpaid participant has died and the spouse is in receipt, the overpayment cannot be recouped from the spouse. To fulfill the fiduciary duty to make plan whole, the plan sponsor may be required to make a contribution if they choose not to recoup the overpayment from the participants.

Secure 2.0 aimed to establish a Lost and Found database by the end of 2024, but meeting this deadline may be problematic, as the IRS has confidentiality concerns with providing participant information from tax records.

To use the **Voluntary Correction Program (VCP)**, the plan sponsor must submit an application to the IRS using pay.gov. Defects that are too "significant" to correct via SCP have to use this program. Examples include some retroactive payments and plan not being administered according to its terms. Plan sponsors who want more certainty may choose to use this program

instead of the SCP. The IRS has recently narrowed what is accepted as a scrivener's error. For example, a large 401(k) administrator inadvertently included equity compensation for a population as eligible plan compensation, and this was never intended. The IRS insisted that it was a cutback and it took convincing to have them accept that this was never intended and would only be corrected going forward. The IRS will generally not audit a plan that is going thru a VCP.

If a defect is found while the plan is undergoing an audit, the **Audit Closing Agreement** Program needs to be used instead of the SCP or VCP. The IRS will assess sanctions that are more than what it would usually take to correct them under the VCP. The fee will be reasonable and the maximum fee is 40% of what the fee would have been if the plan were disqualified.

The DOL has an alternative to the VCP called the **Voluntary Fiduciary Correction Program (VFCP)**. This program is not used nearly as often as the VCP. It is available to correct delinquent 401(k) contributions and delinquent 5500s, and is also used for top hat plan corrections. The max penalty for late 5500s is $2,000/year. The VCFP does not exempt the filer from IRS penalties. As an alternative to VFCP, the plan sponsor can just pay the 10% excise tax on late deposits. Recently, the IRS excise tax filings include a checkbox that asks if the VFCP has been filed. Fair market rate of interest on late contributions is also required. The presentation includes links to the online calculator, checklist, and model application form.

What could go wrong in plan administration

- **Missing pay and service data** happens with recordkeepers and staff change. Participants previously considered nonvested can turn out to be vested, and participants who were paid lump sums a long time ago may come forward and claim the lump sum again. If the plan administrator does not have the records, an option is to get records from the Social Security administration (SSA Form 750) where records go back to the 1990s. Trustees are not a good option for historical data, as their records only go back five years. It is the plan administrator's responsibility to determine if a benefit is due and if it is, to pay it out. When asked if using estimated data is legal, the panel opined that if no better data is available, using estimated data or valuation data to determine plan benefits is more legal than not paying the benefit at all. To the question, "When is it a good time for the plan administrator to dig in their heels and not pay a participant claim?" the panel answered, "When they have some evidence that, for example, the participant's lump sum was already paid." If there is

no evidence of the lump sum already paid, sometimes it will end up paid twice; at least under Secure 2.0 the plan administrator has no obligation to recoup it from participants if it is double paid. The plan sponsor can use ERISA claims procedure to protect themselves. It was the panel's opinion that there is no need to file a VCP to correct missing data.

- **Participants who work long enough can hit the 415 pay limit,** which is not indexed for age. While most practitioners pay attention to the 415 dollar limit, it is often the highest three year compensation limit that is exceeded for some older participants. If the benefit is subject to actuarial increases past age 65, it can exceed the 415 highest three year pay limit for participants who are not highly paid. The active participant's benefit should start as of the date it reaches the 415 pay limit. It is the Plan Administrator's responsibility to keep track of the 415 limits for each participant, but the client staff that fills the role of Plan Administrator is almost never trained in the details of 415 limits and practically cannot keep track of them. It would be a good idea for the actuary to keep track of participants who may be approaching the 415 limit and notify the Plan Administrator, so that they can be put into payment. It was the panel's opinion that there is no need to file a VCP to put these participants into payment.

- Plan Administrators are often confused about the required language in **the Suspension of Benefits Notice** (SOBN): "Why suspend benefits that have not started yet?" and therefore think it does not apply to their plan and don't send them out. When plans merge, previous plan sponsors no longer exist, or recordkeepers continuously change, there is no one to ask if the SOBNs were sent. If it is discovered the SOBNs are not sent on time, for example, during a plan termination, actuarial increases (AIs) must be given on benefits up to the date that the SOBN is finally sent. In one plan termination, the AIs retroactively paid totaled $2M and the plan sponsor had to contribute to be able to terminate the plan. It was the panel's opinion that in the circumstance of the plan termination and the required timing, it was OK not to file a VCP.

- Almost every plan includes **participants past Minimum Required Distribution Date**. These are sometimes spouses of deferred vested participants that have died and were assumed to be married. Plan administrators rarely send out checks to unverified addresses. Some plan documents contain forfeiture language (treat as if deceased and unmarried at death) which is to defend plan sponsors against a claim that benefits that were not found should have been escheated. Benefits can be forfeited according to the language in the plan, but if a participant surfaces to claim their benefit, they must be reinstated. Most actuaries don't delete forfeited participants off the valuation file, and there was some discussion as to whether these forfeitures should ever occur, due to the PBGC's opinion that, upon termination, these are missing participants and should be turned over to the PBGC. Opinions varied about paying PBGC premiums for the forfeited

participants. In a plan termination, these participants will usually go to the PBGC under the Missing Participants program.

- If the language in the **plan document needs to be altered to match how the plan has been administered**, the Plan administrator may need to file for a VCP. Example: plan document says the rate to determine lump sums is "for November" (this rate is published in December) but the rate used in practice is published in November (this rate is for October). The Plan Administrator in this example argued successfully that this was a scrivener's error in the plan document and was able to move forward with corrected language in the plan document and no recalculations of any old lump sums. The IRS has recently become stricter in allowing corrections of "scrivener's errors" and has been demanding corrected payments.

QDRO administration

Avoiding QDROs is more financially efficient to the divorcing parties and instead recommend using 408 transfers/trading other assets for retirement benefits. However, if a DB or a DC plan participant is near retirement, the plan benefits represent a significant portion of the divorcing couple's assets.

There are nine community property states, while the rest of the states are equitable distribution states. In a community property state, the presumption is that all property is community property unless either spouse holds their own title for a piece of property. This principle does not apply to qualified plans, because the Plan Administrator has a fiduciary obligation to other plan participants. The Plan administrator has no fiduciary obligation to the alternate payee until the DRO has been qualified.

The requirements of Section 414p are often misunderstood and result in DROs with benefits to the alternate payee that are ambiguous. QDROs in a defined contribution plans are often more complicated to administer than in defined benefit plans. In a defined contribution plan QDRO, it is much simpler to administer a stated dollar amount going to the Alternate Payee than a percentage of an account balance. Account balances are rarely available at non-month-end dates, are complicated by prior QDROs, participant loans and plan mergers/changes, breaks in service, and are not available very far back if the record keeper has changed. Qualification of DROs is a high-risk task for a Fiduciary because of ERISA's exclusive benefit rules.

Non-qualified plans do not need QDROs because there is no non-alienation clause in these plans.

Session 103

Just Your Average Annuity Purchase Session

Speakers:

- Joseph Anzalone, Managing Director, Agilis (Moderator)
- Kate Breen, SVP Pension Risk Transfer, American National
- Sheena McEwen, VP Head of Distribution, Legal and General Retirement America
- Jay Dinunzio, F&G Annuities & Life
- Shannon Eidson, Defined Benefits Business Leader, TruStage

Session Host: Ted Law, VP & Managing Actuary PRT Pricing, RGA

Background

As the annuity purchase market evolves, so do the insurers. In past Annual Meeting sessions, we've taken a broad view of the market. Speakers in this session will focus on average sized annuity placements and below and the issues associated with them. You'll walk away with the perspective from some of the insurers that participate in small-to-mid sized transactions.

Introduction and Company Overviews

The PRT Market saw a big boom in sales in 2012 due to the large transactions Prudential executed with General Motors and Verizon. Sales dropped back down in 2013 but have climbed steadily since. While 2023 had only $45B in sales, compared with $52B in 2022, the total number of transactions executed increased by 25% from 2022 to 2023. While jumbo deals can drive fluctuations in total dollars of sales year over year, the number of transactions in the "average" size range increases more smoothly.

SECURE 2.0 includes a provision requiring the DOL to provide a report to Congress on the suitability of Interpretative Bulletin 95-1. The DOL provided this report in June 2024, and although the report made no firm recommendations for change, it did propose further consideration to reforms which may include broader public input.

Eight insurers participated in the PRT market prior to 2014. Since that time, one or two new entrants into the market has joined each year to match the increasing demand for transactions. As of 2024, the market has over 20 different insurers, though each insurer has a unique strategy for targeting certain markets. The panelists represented 4 insurers with various market targets ranging from an average size of $6M, all the way up to a maximum deal size of $1.5B.

Process, Timeline, and Transition

Over the last 10 years, the bidding process for PRT transactions has improved dramatically and become much more standardized. Consultants have begun sending expected pipelines through

the end of the year, as well as providing typically several months for the timeline of each bid. Defined processes are much more important in the smallest end of the market, where insurers may have 3-4 bids in a single day. With so many new entrants, plan sponsors have more options and can receive more favorable pricing. In addition to benefits of increased competition, insurer pricing has improved through additional diversity in investments and increased precision in mortality modeling. However, the market continues to present the need for more human and capital capacity to meet the demand of plans seeking annuity purchases. Retiree-only bids are typically lower than the plan's Projected Benefit Obligation (PBO), assuming the PBO is based on appropriate assumptions. Transactions which include deferred lives often transact above PBO due to additional risks and administrative costs.

The timeline for a successful process is dependent on the size of the deal, with average deals closing in 6-8 weeks. Larger deals with an independent fiduciary often require at least a 3 month lead time, while micro-sized deals can last only 2-3 weeks. Providing an initial timeline is essential for success, but it can be helpful to be willing to change the timeline depending on overall pipeline. Sometimes transactions can get bunched up at a certain point in the year, but this doesn't necessarily occur at year-end. Advanced negotiation of the commitment agreement and schedule transparency are very helpful for insurers.

If plan sponsors provide clean data, the process can go more efficiently. For example, if the client is not performing regular death searches, the timeline to onboard the deal and mail out certificates can be delayed. Providing data post-lump sum window can allow for more precise insurer pricing, however using a buy-in contract can be a useful tool to obtain locked-in insurer pricing prior to any lump sum windows. While buy-ins have some additional complexities, many insurers offer a viable solution and increased use of buy-ins is being seen on larger transactions ($500M+).

Participants living in New York can drive additional complexities as insurers often have a separate entity to write New York business due to a more stringent regulatory environment than other states. If an insurer is licensed in all 50 states, then no problem, but not all insurers have a New York license. Many insurers offer a 49+1 solution where New York participants are written out of one legal entity while the remaining participants fall under a separate group annuity contract. If the contract is being issued in New York, sometimes that New York entity needs to be licensed in all 50 states, which can eliminate some insurers.

Additional growth in the market may be seen with multiemployer plans and public pension plans. The market continues to boom, and the more plan sponsors can align their transaction with standard procedures, the easier the process will be and the more competitive the insurer pricing will be.

Session 106

Total Well-Being: How Forward-Looking Employers are Responding

Speakers:

- Paul M. Sepe – Managing Director, Integrated & Global Solutions – WTW
- Riddhi Patel – Director, Retirement Programs – The Walt Disney Company
- Robert G. Holdom – Head of Total Rewards – Mars Veterinary Health
- Scott Ramsay – VP Benefits – Prudential Ins Co of America
- Una Raghavan – VP Total Rewards – Securitas

Session Assistant: Steven F. Cyboran – CEO, Consulting Actuary – Humaculture, Inc.

Session Overview

Employees' physical, mental, social, and financial health impacts their productivity and engagement – making it a business imperative. Employers are focusing on the diverse needs of its multigenerational workforce in developing their well-being approach. In addition, questions about the ROI of these programs require strong strategy and governance to maximize the impact of these programs. Join us for this interactive session.

Context Setting: Executive Summary from Employer Survey

Employers are leaning into well-being. According to a post pandemic survey of 3,600 employers, employers continue to focus on employee well-being to help attract and retain talent. Companies with the most effective approaches report better human capital and financial outcomes. Recent investments have had positive effects on employees' attitudes, yet employee well-being has not improved and many still have major challenges. Mental health remains a concern and more support is needed. Many employers have not delivered on financial well-being, which is employees' top issue. Employers look beyond programs and aim to enhance the employee experience to connect well-being to their human capital strategy.

Companies expanding use of well-being as the basis for human capital strategy

While the current highest priority of well-being for employers is physical (32%), the shift over the next three years is to begin focusing on holistic well-being as a human capital foundation (from 21% to 46%) and embed into company culture (from 30% to 32%). Benefits teams have been the owner of well-being, but it is moving to cross-functional HR teams, because it requires the talent and culture teams. Middle management is key to employee well-being, but often presents a challenge in getting the message out. Leaders are asked to do a lot as it is; it is hard to get them to focus on another initiative. Before you can even get to the culture concept, a cross-functional team is needed to address pay, benefits, and culture to equip leaders to take care of employees.

Why focus on well-being?

It is imperative that employers give their employees the flexibility they need to detach from work, rest, and recharge. Leaders view well-being not just as an employee benefit, but as an opportunity

to support employees in all aspects of their personal and work lives. Young people are now more likely to leave their job voluntarily to preserve their mental health.

A Deloitte study found that 60% of employees and 64% of managers are considering quitting their job for one that better supports their well-being. A McKinsey study found 59% of employees report at least one mental health challenge, who are 3x more likely to report low job satisfaction and 2x more likely to report low engagement. According to the Headspace Fifth Annual Workforce Attitudes Toward Mental Health 92% of employees overwhelmingly agree that they are better at work when their mental health is strong; the same is true for CEOs (95%).

Occasionally an article will come out indicating that wellness programs have little impact. Sponsors need to be able to address the objections. Not all well-being programs are created equally. There is a range of effectiveness in well-being programs.

An Aon study documented how business outcomes are better for companies with a higher well-being summary score. It was pointed out that correlation is not causation. Companies with more revenue can invest more in well-being programs, which may be why more profitable companies invested more in well-being.

The WTW Global Benefits Attitude Survey found better well-being is associated with higher levels of retention, engagement and employee performance. Well-being is used to bring in top tier talent, because employees are demanding more well-being. Well-being needs to move beyond the traditional benefits. They want more out of their career with growth and flexibility. An employer needs to show that you care about employees across different demographics segments. Employees want to know that the company cares for them and keeps their best interests in mind, which makes it less likely that they will leave.

Well-being needs to be re-embedded in the culture. It is important to create a mission statement for well-being. For example, “Bring your best at work and home.” People doing their best will bring their best. This goes beyond physical and emotional. Financial issues also have a big impact to an individual’s overall well-being.

There is no such thing as over communicating. While you may not be able to prove well-being causation, you can make the case for what it is costing if you do nothing. It doesn’t necessarily have to cost you a lot of money, but it could be the way you communicate what you are doing.

What intergenerational issues will change over the next 10 years? The Gen X and Y segments of workforce have such a high expectation from the employer that goes beyond what an employer may be willing to do. To really understand the underlying trends, an employer needs to do a lot of informal surveys and focus groups to keep a pulse so that you can adapt.

The in-your-face requests, feedback, and demand are greater than ever. A campaign of “Maintain, don’t Gain” can result in an uproar of fat shaming, etc.

To find the budget, it isn't necessary to request additional budget. For most companies, 50% to 70% of the operating budget is in people. Investing those dollars just a little differently from a behavioral perspective can result in significantly better outcomes.

Business Case – Outcomes – How to measure "return" on well-being programs
Leading organizations focus on measuring the value of their investment in well-being. This includes a wide range of health care, clinical, absence, safety, population, participation, and organizational measures to evaluate both the return on investment and value on investment. Measuring the effectiveness of well-being programs should include the building blocks of activity metrics, well-being metrics, cultural metrics, and ultimately link to business performance.

Many organizations are still trying to figure out how best to make the business case. Rather than showing an ROI, find a problem and solve it with a well-being program. Some organizations create a well-being index and illustrate how it is correlated to workforce and business outcomes. How much is a change in a metric worth? Rather than doing an extensive new study, see what can be gleaned from existing engagement surveys. Look for correlations between demographic groups and outcomes.

What is the potential return for a particular program? It is important to consider the lag factor. For example, tobacco programs take years to see an outcome. There are also optics that need to be considered. A tobacco cessation program that leads to security officers not taking smoking breaks looks better to customers. Well-being programs also say we care about our employees. And also consider outside factors that may skew the results. For example, metrics showing a financial well-being program put in place during the 2008 financial crisis was a huge success might not really be because of the program, but rather because people recovered naturally from the crisis.

Once you get outside the US and medical claims aren't available, you need to look at other measures, such as customer service. To do that, look to link self-reported well-being and customer service statistics. The top categories of well-being have 3 points higher customer satisfaction than those on the low end. Then document that the difference is worth $x million.

Employer vs. Employee Focus
The 2024 WTW Global Well-being Diagnostic Survey and 2024 Global Benefits Attitudes Survey found that employers are more likely to focus on emotional well-being (66% employers vs 41% employees), physical well-being (52% employers vs 40% employees) and employee experience (50% employers vs 40% employees), while employees focus more on social well-being (17% employers vs 20% employees) and financial well-being (22% employers vs 59% employees).

Financial well-being is where there is the biggest gap between employers and employees. Employees want employer support to address a range of financial needs (2024 Global Benefits Attitudes Survey, Global). There is organizational resistance to addressing financial well-being, because leaders don't want to get into the financial well-being of their employees and there is concern that a focus on financial well-being might create the impression that pay is inadequate, particularly in a unionized environment. Leaders find the finances of employees to be very personal, but the surveys demonstrate that financial issues are a basic need. There are also

generational considerations with financial well-being. For example, younger employees are more free in sharing information about their financial situation. We need to figure out how to talk to different groups who have different needs and expectations.

To communicate around financial well-being, consider passive communication and hope employees see and share the information. Rather than talk about credit card debt, discuss how to manage debt more broadly. Help leaders understand that employees who are fiscally responsible with their personal resources will also be more fiscally responsible with corporate resources.

Session 107

Public Plans White Paper 2.0

Speakers:

- Paul Angelo, FCA, FSA, EA, MAAA – Retired
- Andy Blough, FCA, FSA, EA, MAAA – Indiana Public Retirement System
- Wendy Ludbrook, FCA, FSA, EA, MAAA – CavMac

Session Host: Piotr Krekora, FCA, ASA, MAAA – Gabriel, Roeder, Smith & Company

Overview

In August 2024, the Public Plans Community of the Conference of Consulting Actuaries (CCA) released a second edition of their 2014 white paper "Actuarial Funding Policies and Practices for Public Pension Plans" ("White Paper"). Speakers at this session, representing the drafting group, focused on changes between the first edition and the "White Paper 2.0" including changes made in response to comments from the public sector community.

First Edition

Prior to the issuance of the Governmental Accounting Standards Board (GASB) Statement Nos. 67 and 68, actuaries and their clients frequently based their funding practices on pension expense boundaries laid out in pension accounting standards (Statement Nos. 25 and 27). Promulgation of Statement Nos. 67 and 68 marked GASB's attempt to separate accounting from funding, and the new standards deferred to guidance in Actuarial Standards of Practice (ASOPs). However, then-current ASOP No. 4, providing guidance with respect to measuring obligations under a defined benefit pension plan, did not address issues specific to public sector retirement systems. As such, the GASB approach to separating accounting from funding created a void that needed to be filled. Several organizations made attempts to fill this void, including the State of California through the chartering of the California Actuarial Advisory Panel (CAAP). CAAP, composed of actuaries appointed by various stakeholders, was created to assist public agencies with advice related to pensions and other post-employment benefits. The CCA work group for the first edition of the White Paper, which included some members of the CAAP, started their work with a draft of a CAAP document. The focus was on a plain vanilla, ongoing plan. Avoidance of complexities and special features allowed for finishing the paper without overly complicated deliberations, and the White Paper was published in October 2014.

Second Edition

The Public Plans Community Steering Committee announced in February 2022 a project aiming to refresh the White Paper. The project was undertaken to preserve and enhance the credibility of that document, reflect emerging practice and experience with White Paper 1.0 observed over the eight years after its publication, reflect new ASOP 4 guidance (significantly more detailed when

compared to the 2012 version), and enhance coverage of some topics. Similarly to the first edition, White Paper 2.0 focuses on plain vanilla retirement systems, with the steering committee expressing an intent to supplement the effort with "side papers" addressing special features and details of sub-topics. The drafting group was intentionally selected to include two authors of the first edition who were joined by nine actuaries from different actuarial firms representing the newer generation. The draft was exposed for comments in May 2024. The second edition of the White Paper was released on August 21, 2024, after two and a half years (66 full group conference calls) since the start of the project.

Paper Objectives

The second edition reinforces the prior guidance for developing a policy-based actuarially determined contribution. This guidance is built within the Level Cost Allocation Model (LCAM). It is based on five general policy objectives: Contribution Sufficiency, Demographic Matching, Volatility Management, Transparency and Accountability, and Sound Governance. These are the same objectives that were considered in the first edition, but the concepts have now been given labels consistent with industry practice. Guidance is presented in the form of categorization of various policy elements, with the same categories as used before (but the second edition enhances descriptions of categories): LCAM Model (most consistent with the general objectives but not intended to be referred to as "best practice"), Acceptable (well established and consistent with general objectives), Acceptable with Conditions (may require some analysis to show consistency with general objectives), Non-Recommended (consistent with different objectives than the LCAM), and Unacceptable (not meeting actuarial standards, or not consistent with general policy objectives).

Actuarial Cost Methods

Actuarial cost allocation methods are mostly the same as discussed in the first edition. The most notable changes include an appendix housing additional descriptions of various cost allocation methods and a more detailed discussion of different entry age cost method variants: averaged (or traditional), replacement life, and ultimate. Revisions to this section resulted in downgrading the ultimate entry age cost method to "Unacceptable" mainly because this method does not comply with ASOP No. 4. Under ASOP No. 4, individual cost methods must base the normal cost on the current benefit structure applicable to a given member. In contrast, the ultimate method develops normal costs by applying the newest tier provisions when determining the normal cost for all members. The main criticism of the ultimate entry age cost method is that it changes contribution requirements and accrued liability based on changes in plan provisions applicable to new hire members, even though the current members with accrued benefits are not affected by the plan design changes.

Asset Smoothing Methods

There are very few changes to asset smoothing methods in the second edition. The most notable changes result in downgrades of rolling smoothing methods: 5-year rolling smoothing with an 80%/120% corridor was downgraded from Acceptable to Acceptable with Conditions and calls for

a projection of when the actuarial value of assets would be expected to approach a reasonable range around the market value of assets. In addition, 10-year rolling smoothing with a 90%/110% corridor is now considered "Non-Recommended", a downgrade from "Acceptable". Furthermore, market value (without smoothing) is downgraded from "Acceptable" to "Acceptable with Conditions" and requires other forms of volatility management as a condition.

Amortization Methods

The amortization methods section of the White Paper is probably the most heavily edited section of the document. Some changes focused on clarity and consistency, but numerous edits changed or added content compared to the first edition. Key updates are intended to ensure consistency with ASOP No. 4 and to require that the sum of outstanding balances equals the unfunded Accrued Liability. Additional edits create stronger ties between the general policy objectives and the specific policy discussion items, clarify or remove time-dated references, and provide more supporting rationale to accompany the methodology categorizations.

The most notable change in this section upgrades the level dollar amortization method from Acceptable to falling within LCAM Model practice. In addition, details are added to discuss the amortization payment increase rate and various implications of amortization method selection. The second edition defines "Tail Volatility", a term that was used before without definition. It presents synchronizing the remaining amortization periods for offsetting bases as the preferred method for managing Tail Volatility. The effect is similar to combining amortization bases with the advantage of preserving the histories of individual bases. This base synchronization method replaces combining bases as a model practice, with the combining bases downgraded to "Acceptable". Other changes include downgrading rolling amortization methods for assumption and method changes that do not reduce the outstanding balance by a reasonable amount each year and rolling amortization for plan amendments to unacceptable. Furthermore, any rolling amortization method resulting in a negative amortization is now deemed "Unacceptable."

Conclusions

This second edition of the White Paper refreshes actuarial funding policies based on the Level Cost Allocation Model for application with traditional defined benefit public pension plans open to new members and pre-funded using an actuarially determined contribution. Revisions are intended to improve non-actuaries' accessibility and to align the model with emerging practices and revised ASOPs. However, like the first edition, this White Paper is not an Actuarial Standard of Practice issued by the Actuarial Standards Board, nor does it provide guidance on compliance with the ASOPs.

Session 203

Retiree Medical Plan Design and Fundings Opportunities

Speakers:

- Jeremy Olszewski, FCA, FSA, EA, MAAA – Fidelity Investments
- Steven Draper, FCA, FSA, MAAA – Ernst & Young
- Kevin Penderghest, FCA, ASA, MAAA – Gallagher

Session Host: Jeannie Chen, FCA, ASA, EA, MAAA – Deloitte Consulting

Retiree Medical Plan Designs

Before FAS 106 (1990), over 50% of large employers offered retiree medical plans but today only about 20% offer these plans. Traditionally, employers that offer retiree medical plans provide a continuation of active coverage likely with different retiree contribution structures. Due to increases in healthcare costs and the introduction of FAS 106, many employers have used different approaches to control cost and OPEB liability. This section highlights pros and cons of these approaches.

A Retiree Exchange is an arrangement where retirees are given access to a platform to purchase plans for themselves, instead of accessing the employers' limited plan options. This is typically paired with a Health Reimbursement Account (HRA). Within an Exchange, retirees have more plan options than usually offered by employers. Retirees that are generally healthy can choose a lower cost plan while those with more expected costs can choose a richer plan. While Exchange vendors generally provide transition assistance, communication is key so that retirees are notified in advance and prepared for the changes in accessing their benefits. Another approach to funding an HRA annually is to provide a total balance for retirees to draw down over their lifetime. The liability for this type of account balance approach is generally based on how quickly retirees are expected to use these funds.

Employers generally have more control of the liability since it's driven by HRA subsidies instead of changes in healthcare premiums. The employer's cost may not always be clear as it is dependent on how subsidies are designed. Examples of factors that determine employer's cost and OPEB liability are the amount of employers' HRA contribution, whether the contribution increases with CPI, or whether unused amounts rollover at the employers' discretion. When determining the accounting treatment of moving to an Exchange, there is typically a significant change from current plan design which would need to be measured as a plan amendment. If the design offered and employer's contributions are not changing, it could be considered a change in delivery method (gain/loss) and not a plan change. It is important to discuss the approach with auditors about the appropriate accounting treatment.

Medicare Advantage (MA) group plan is an all-in-one alternative method of providing benefits to Medicare retirees. Over half of Medicare retirees are now in MA plans. They are offered by private insurers that handle every aspect, including receiving Medicare reimbursements, in exchange for providing benefits to retirees. MA plans are typically a cost saving to employers as insurers offer a higher degree of care management, may require pre-authorization for specialist care, and may have more limited provider networks. MA plans can be designed to be consistent with the benefits currently offered to reduce retiree disruption. Depending on covered population and plan design, insurers may offer $0 premium MA plans. They also typically offer premium guarantees for multiple years. However, premium guarantees may not be honored if there are changes due to legislation or CMS subsidy calculation methodology.

When valuing the liability of a $0 MA plan, the projected claims and CMS revenue used to determine the insurers' rate quotes could be used as the building blocks of the per capita cost assumption. It may be appropriate to apply different trend assumptions to claims and CMS revenue and build in increases over time. It is also important to build in CMS revenue projections that are released each year.

Prior to ACA, prescription drug benefits were typically provided as a continuation of the current active plan and employers could apply for Retiree Drug Subsidy (RDS) and provide an actuarial attestation to show the plan is actuarially equivalent to Medicare Part D in order to get reimbursed for a portion of the costs. After ACA, employers are now able to offer standard Part D plans supplemented with a wrap to obtain EGWP subsidies that are significantly higher than RDS. With the Inflation Reduction Act (IRA) and the standard Part D design being more rich in value as a result, employers who have not moved to EGWP are now considering making this change since it is more difficult to maintain actuarial equivalence and receive the RDS. While IRA also changed EGWP subsidies, it is still more financially favorable than RDS. EGWP subsidies and RDS should be reflected under ASC 715 but RDS cannot be reflected under GASB 74/75.

Retiree Medical Plan Assumptions

Actuarial practice continues to move to more defined and accurate assumptions. For example, when discount rate was determined 25 years ago, it was common to round to the 25 basis points. Now rounding is usually to the nearest basis point. When disclosing assumptions, it is important to label assumptions very clearly so that readers of the report can understand how the assumptions are intended to be applied. For example, trend for a year should specifically state whether it is the trend to the next year or the trend rate from the prior year. This section highlights considerations for setting and disclosing assumptions.

First year healthcare trend assumption could, and likely should, reflect next year's rate renewal information that may be available when preparing year-end disclosures. When there is a large difference between actual and assumed trends, this could lead to material misstatements. Due to provider contracting, the inflation we saw in 2021 and 2022 had a delayed impact on healthcare costs. Given the delayed impact of inflation on healthcare trends, there may be excess inflation of

2% - 3% reflected and spread over the next 2-3 years. For clients with rate guarantees, the effect of high inflation would not hit immediately, but could be reflected in years after the expiration of the rate guarantees. For MA and Part D plans, consider separate trend assumptions for claims and offsets to properly account for and project the leveraged impact on premiums.

With the prevalence of caps and reduced employer subsidies, retirees may not be participating in the retiree health plan or participate in their spouse's plan instead. Therefore, it is important to study and disclose participation and persistency (lapse) assumptions and consider whether these assumptions should vary between pre-Medicare and Medicare populations, particularly if the subsidy levels differ.

Persistency is an assumption of how many retirees would re-elect each year, or how many retirees would lapse each year. If caps are in place and contributions increase faster than trend, a lapse rate assumption may be applicable to reflect expected behavior.

For HRAs that provide a lump sum at retirement, consider the participation rate along with the time period over which the balances will be used. Reviewing plan provisions is important. For example, understanding if there are caps on annual benefits may influence if balances have to be used by a certain date. These could in turn impact the draw down assumption.

Funding Retiree Medical Plans

Retiree medical funding mechanisms have not changed much over the years. Pre-funding retiree medical plan is rare because employers generally are not required to pre-fund as benefits are not guaranteed. Funding may suggest that these benefits are permanent cash and is considered to be better used for other purposes.

A 401(h) account allows funding of retiree medical benefits through a separate "account" within a larger pension trust. There are over funded 401(h) accounts where the plan sponsor is looking for ways to get that money out because it is likely be subject to 50% excise tax on reversions. Some potential remedies include increasing benefits for eligible employees, expand pension participants eligible for retiree medical coverage, or providing enhanced retiree medical benefit within an early retirement window.

The maximum tax-deductible contribution (MTD) to a VEBA trust is calculated by an actuary. For employers who want to put in the MTD, this can be tricky as contributions have to be in the trust within the year but often times, the necessary components to perform this calculation aren't available until after the end of the year.

Session 205

Large Claimant Trends and Risk Mitigation

Speakers:

- Douglas Punt, FSA, MAAA – Symetra
- Leslie Lucas, FSA, MAAA – Mercer

Moderator: Jennifer (Jenny) Leming, FSA, MAAA, FCA – Mercer

Session Host: Paul Albarano, FSA, MAAA, FCA – Alliant

Overview

Healthcare cost trend inflation is the highest it has been in years. A significant driver of this has been rising costs associated with large claimants. In this session, the speakers address the main causes of these large claimants – on both the medical and pharmacy side – potential risk mitigation strategies and the responses large, self-funded employers have taken to combat these significant cost pressures.

Large Claims Background

Key drivers of large claimants (i.e., claimants exceeding $200,000 in medical/Rx paid claims), based on medical diagnoses are malignant neoplasm, cardiovascular, leukemia/lymphoma/multiple myeloma, newborn/infant care and transplants. These top diagnostic areas have been evolving over the most recent 3-5 years, with neoplasms/cancers and diseases of the circulatory system both increasing in prevalence. A multitude of risk mitigation strategies exist for these large claimants, including stop loss insurance, alternate payment models, predictive analytics, case management, chronic disease management, network management, utilization management, Pharmacy Benefit Managers (PBM) managements and bill review. Some have reported Reference Based Pricing (RBP) as being effective in driving large claimant costs down over the most recent 3 years, even resulting in slightly negative year-over-year claims trend, compared to positive year-over-year claims trend with traditional PPO networks.

Gene therapy drugs have also been a significant driver of the recent rise in large claimants. The incidence of gene therapy treatable patients is currently expected to increase considerably in the near future, with some therapies exceeding $4,000,000 in total estimated claims cost.

Employer Perspective

Health benefit cost per employee is projected to rise above inflation again and many inflators are related to high-cost claimants (e.g., cost impact pressures from hospitals and providers, Rx inflation and the rise of behavioral health).

Based on a survey of CFOs of companies with 500+ employees, a majority believe that annual increases in health care costs of CPI or less are sustainable while many CFOs believe business results would be materially impacted if actual experience exceeds budget by more than 4%. Based on what we know of expectable claims volatility, many clients could exceed this creating a disconnect with CFO expectations.

Strategies exist for managing claims volatility, including proactive communication/expectation management, funding arrangement, level of stop loss coverage, appropriate level of conservatism in budgets and accruals, clinical management / steerage to high value care, and strategies to share costs between employers / employees (e.g., plan design, contributions, network). Further, managing high-cost claimants and managing cost for expensive specialty drugs are the two most important strategies for larger employers.

Various funding methods, spanning from fully insured coverage (which provides less risk for the employer) to self-funded without stop loss (which provides more risk for the employer), exist to help employers manage the risk of claims volatility. Similarly, stop loss coverage – both aggregate stop loss and individual stop loss – exist to specifically help employers manage the claims volatility of high-cost claimants. Funding and stop loss considerations change as employers grow in size (budget size and population size). Strategies for managing gene therapy cost exposure also exist, such as: gene therapy carveout coverage (1st dollar coverage), conventional stop loss coverage, gene therapy only stop loss policy (covers only the cost of the gene therapy drug), gene therapy networks discount contracts, and outcomes-based agreements.

Session 207

GFOA Best Practices and Advisories

Speakers

- Todd Tauzer, FCA, FSA, MAAA, CERA – Segal
- Noreen Jones, CFA, CPA, FRM – Nat. Assoc. of Public Pension Attorneys
- Amy McInerny, CPA – San Bernadino County Employees' Retirement Association

Session Host: Jody Carreiro, FCA, ASA, MAAA, EA – Osborn, Carreiro & Assoc.

Overview

The Committee on Retirement and Benefits Administration (CORBA) of the Government Finance Officers Association (GFOA) issues best practices (do this) and advisories (don't do this) related to public pension and OPEB plans. In the last two years, CORBA has made a strong effort to review and update many of these documents. Speakers at this session discuss what's new and notable within CORBA's best practices and advisories for public retirement actuaries. These will include the Best Practice on "Core Elements of a Funding Policy for Governmental Pension and OPEB Plans", the Best Practice on "Sustainable Funding Practices for Defined Benefit Pensions and OPEB".

GFOA, CORBA, Best Practices and Advisories

The Governmental Finance Officers Association (GFOA) has over 23,500 members from the United States and Canada. The 7,800 member organizations represent cities, counties, school districts, state, provincial, and other special districts. Their areas of responsibility include accounting, auditing, budgeting, capital planning, and other related areas. The GFOA works to promote excellence in finance by developing Best Practices and Advisories through various standing committees of its membership and other affiliated professions. One of these is the Committee on Retirement and Benefits Administration (CORBA) which does include actuaries.

GFOA Best Practices identify specific policies and procedures that contribute to improved government management. They aim to promote and facilitate positive change or recognize excellence rather than merely codify current accepted practice. There are currently 171 Best Practice papers covering many topics. They are generally from 2 to 6 pages in length. The current goal is to expand the use of case studies and add actionable checklists to these papers as they are updated. GFOA recognizes and award areas of Best Practice instead of policing those who do not follow the high standard set. Some examples of CORBA Best Practices include papers concerning design elements of DB plans, asset allocation for DB plans, the role of the actuarial valuation report in plan funding, hybrid retirement plan design, and OPEB governance and administration.

CORBA also issues Advisories in the area of retirement and benefits administration. GFOA Advisories identify specific policies and procedures that help to minimize a government's exposure to potential loss in connection with it financial management activities. Some examples include deferred retirement option plans (DROP), pension obligation bonds, OPEB bonds, and early retirement incentives.

The purpose of this session was to familiarize and educate public plan actuaries on the relevant work that the GFOA CORBA does and how it could affect the day-to-day work of the actuary as well as the policies and procedures of the plan. There are two recently revised Best Practices relevant to actuaries to be discussed in particular for the remainder of the session.

Core Elements of a Funding Policy for Governmental Pension and OPEB Plans
This existing Best Practice was recently updated and recommends that governments adopt a funding policy that provides reasonable assurance that the cost of benefits will be funded in an equitable and sustainable manner. These principles were expanded to apply to OPEB plans as well as pension plans. It uses the term Reasonable Actuarially Determined Contribution (ADC) which is consistent with Actuarial Standard of Practice (ASOP) 4. ASOP 4 says the actuary should disclose the reasonable ADC, this Best Practice says the employer should fund the reasonable ADC. The Best Practice refers to core elements of a Funding Policy that are similar to those in ASOP 4 and the recent update to "Actuarial Funding Policies and Practices for Public Pension Plans". That is, an actuarial cost method, asset smoothing method, and an amortization policy which are consistent. The Best Practice then adds a surplus management policy which should guide the prudent management of any potential "surplus". This includes a review of risk reduction discussions that should take place in those situations. The reader may also see the American Academy of Actuaries Issue Brief "Surplus Considerations for Public Pension Plans". This Best Practice brings another viewpoint to this discussion which the consulting actuary may use to help guide clients to good funding policies that are followed with funding. This Best Practice is found at: https://www.gfoa.org/materials/core-elements-of-a-funding-policy

Sustainable Funding Practices for DB Pensions and OPEB Plans
This Best Practice on funding practice is clearly linked to the above discussion on funding policy. Governments should ensure that the costs of defined benefit pensions and OPEB are properly measured and reported. Governments that sponsor or participate in DB pension plans, or that offer OPEB, should contribute the full amount of their actuarially determined contribution (ADC) each year. This update has also made the best practice treatment of OPEB plans the same as it is for pension plans.

This Best Practice (as well as the previous one) makes clear that the target ratio of the funding policy is 100% or more. The funding and amortization methods should be discussed with the actuary and selected to reduce the volatility of the ADC. A couple of items of note that are a step beyond current practice in many places are having an actuarial experience study performed at least every 3 years. Also, it recommends a comprehensive actuarial audit of the actuarial

valuations at least every five years. These last two points are new to this update of the Best Practice. This Best Practice document is found at: https://www.gfoa.org/materials/sustainable-funding-practices-for-defined-benefit-pensions

Session 209

Interest Rates

Speakers:

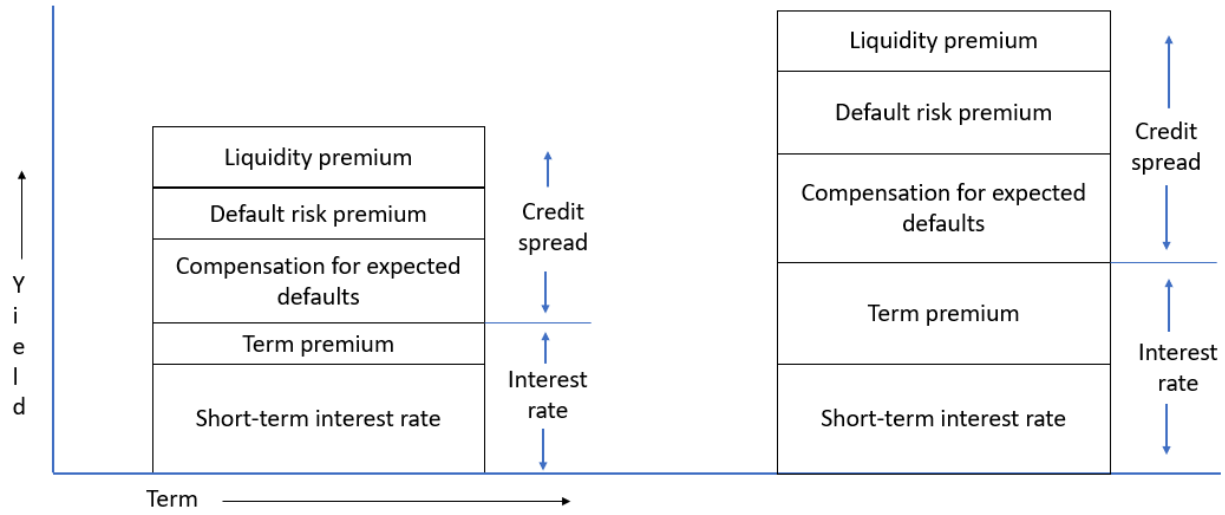
- Jonathan Barry, FSA, EA, CFA – MFS Investment Management
- Michael Clark, FCA, FSA, EA, CFA – Agilis
- Jay Love, CFA – Mercer
- R. Evan Inglis, FCA, FSA, EA, CFA, – Pension Benefit Guaranty Corporation

Session Host: Yangyan Hu, FSA, EA, CFA – LGRA

Overview

This session started with basics and fundamentals about interest rates and what drives the changes in interest rates, followed by a more in-depth discussion on where we are now with interest rates and wrapped up with what impact the current interest rate environment may have on the future.

Fundamental of interest rate and what drives changes in interest rates



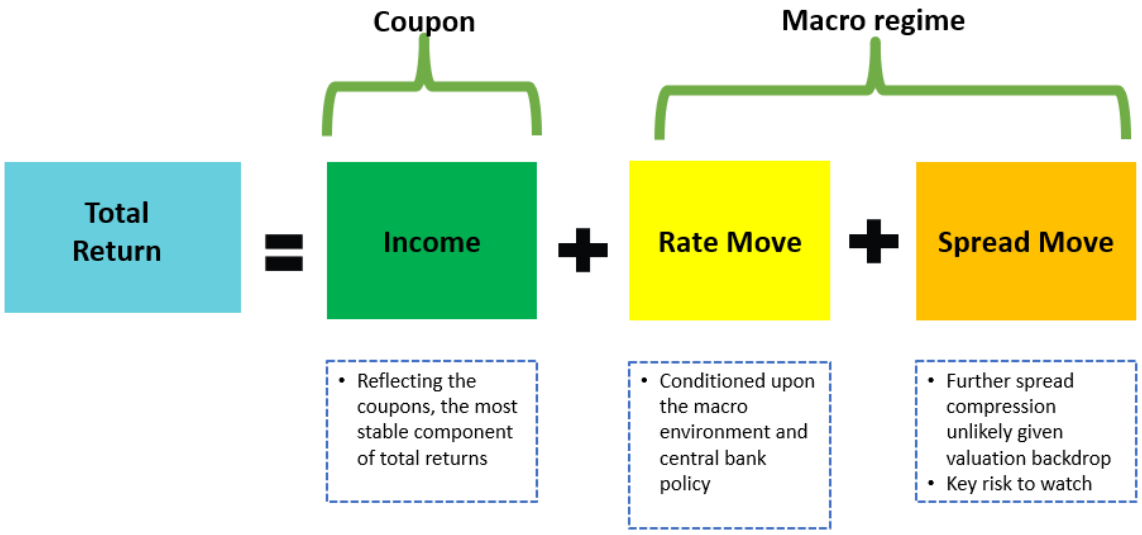
Interest rates are the Treasury yields that the U.S. Government pays to borrow money from investors to fund its operations, which are traditionally viewed as the "risk-free" rates.

Short-term rates (fewer than 10 years to maturity) are driven by the Fed Funds Rate, and long-term rates (10+ years to maturity) are driven by economic conditions, inflation expectations and expectations for the Fed Funds Rate.

The Fed Funds Rate is set by the Federal Open Market Committee, with the goals of full employment and controlling the level of inflation. Such goals can be achieved by changing the Fed Funds Rate, the interest rate at which depository institutions lend reserve balances to other depository institutions overnight. In addition, the Fed can achieve the goals by controlling the money supply through the buying and selling of Government securities as well as adjusting reserve requirements, thereby changing the amount of money in circulation.[1] A looser monetary policy means an increase in money supply, resulting in lower interest rates, which tends to lead to higher inflation. The Fed often tightens monetary policy by increasing interest rates to fight higher inflation.

Historically, a long period of liberal monetary policy and historically low rates followed the capital market crisis of 2008. Then, the Covid crisis brought a flood of fiscal stimulus, and inflation surged. In response, the Fed tightened monetary policy and rates rose dramatically.

What drives Fixed Income Returns



Current Interest Rates Environment

1. Labor force participation rates have generally decreased since the late 1990s, with a big dip in 2020 due to Covid-19 and gradually picking up to the pre-Covid levels. Lower labor supply increases the cost of labor, leading to higher inflation.
2. Federal debt has risen rapidly over the past 20 years, especially with significant fiscal spending since Covid: Covid ($4.3T), CHIPS ($80B), Inflation Reduction ($228B), Infrastructure ($200B)

[1] In recent years, the Fed has controlled the money supply by changing the interest rate provided to banks on their reserve deposits. See ample reserve policy description.

3. The Fed Funds Rate increased from close to 0 at the beginning of Covid to 5.5% in mid-2023 for almost a year. The Fed Funds Rate was lowered to 5% recently, with the expectation to further lower it to 3% – 3.5% over the next year and a half.
4. Treasury yield curve: Lower short-term rates stimulate the economy, increasing growth and inflation, which pushes up long-term rates relative to short-term rates. It's interesting to note that rates went up during October 2024, even with the speculation that the Fed may cut rates due to uncertainties ahead of the U.S. election.
5. Historically, an inverted yield curve where the U.S. 10-year yield is lower than the 2-year yield is typically a precursor to a recession, as is what happened in the early 1990s recession, the early 2000s dot-com bubble, and the 2008 financial crisis. The yield curve had been inverted for well over a year since Covid until recently. So far, there has been no recession.

How Interest Rates Interact with the Economy

1. Higher interest rates lead to higher mortgage and credit card rates.
2. However, higher interest rates have not impacted the economy more, as the U.S. economy has become less interest rate sensitive, and U.S. consumers are less levered when they are able to pay down some debts and refinance to lock in lower mortgage rates when interest rates were low pre-Covid.
3. Fixed income demand has been on the rise, which keeps rates low. However, U.S. Treasury supply has also gone up and will stay up for a long time, which in turn will push rates up.
4. U.S. investment grade credit spreads are at historical lows, averaging about 130 basis points for the past 10 years, down from over 350 basis points in mid-2019 to about 90 basis points in October 2024.

Session 305
Health Equity – Affordability and Access to Care

Speakers:

- Annette James, FCA, FSA, MAAA – Ibis Actuarial Consulting
- Sara Teppema, FCA, FSA, MAAA – Wildflower Health

Moderator: Thuong Broaden, FCA, ASA, MAAA – Deloitte

Session Host: Sam Meyer, ACA, ASA, MAAA – Gallagher

Background

To have a conversation on health equity, we first have to define some of the key terms that will be used throughout the discussion. Health equity means that everyone has a fair opportunity to be as healthy as possible, health disparities are differences in health or key determinants that adversely affect certain groups and social determinants of health (SDoH) are the non-medical factors that influence health. Said another way, social determinants of health are the external factors that lead to health disparities, and disparities are what we want to eliminate in order to achieve health equity.

Dimensions of Health Equity

There are a number of dimensions that can be used to stratify a population when looking for differences in health status including but not limited to: race/ethnicity, gender and sex, language, health literacy, socioeconomic status and employment status (active or retired). It's important to keep in mind that these dimensions are not mutually exclusive and there is an intersectionality between the dimensions that can further compound on one another, so it may not be as simple as picking one without considering the impacts of others. Understanding the numerous dimensions and potential interactions can help inform the strategy that one may take when working within the health equity realm.

Another key component of the discussion is the difference between equity and equality. Equality alone is not enough to achieve health equity as it inherently ignores that there are other factors at play which can and do influence health access and outcomes. For example, looking at distance to provider types is a common evaluation for employers, however distance alone does not account for the possible lack of transportation to get to the specific provider. We often discuss the health outcomes as a metric of health equity; however those outcomes exclude the population of individuals who don't get care due to other limiting factors and therefore aren't a complete evaluation of health equity.

Considerations when evaluating health equity programs

As actuaries we like to work with the data that we have and established metrics, for example preventive screening rates, as the basis of our evaluation. When looking at health equity programs though, we need to use a different lens and more flexibility in what we would consider the evaluation metrics or goals. Health equity programs in general take time to take root and we may not see the "return on investment" for many years depending on the structure and area of focus. This means that we need to look for other measurements, outside of costs, that can provide an indication of if the program is hitting the need that it was created to fill. When a program is being developed or implemented, we as consultants can provide

recommendations on what the goals are, but also recognize that the true issue might not be what we thought it was at the start. We also need to recognize that data sources are often incomplete and have bias. Our analysis will only be as good at the data that we have, so new considerations will be needed when using data in relation to health equity programs.

Session 306

Navigating the Gator-Infested Waters with Assistance from the ABCD

Speakers:

- John Schubert, MAAA, FCA, ASA
  Chairperson, Actuarial Board for Counseling and Discipline
- William Hines, MAAA, FSA
  Vice Chairperson, Actuarial Board for Counseling and Discipline
- David Driscoll, MAAA, FCA, FSA, EA
  Past Chairperson, Actuarial Board for Counseling and Discipline

Session Host: Rick Vandenberg, FCA, FSA, MAAA – Marsh McLennan Agency

This presentation serves as an overview of the ABCD (Actuarial Board for Counseling and Discipline) and underscores the significance of ethics and professionalism within the actuarial profession. As the U.S. actuarial organizations are self-regulated, they need to have structures and guardrails in place to uphold the integrity and reputation of their profession. These structures are highlighted by the USQS (Qualification Standards), Code of Professional Conduct and the ASOPs (Actuarial Standards of Practice) with the ABCD serving as mediator, counselor and investigator for the various U.S. member actuarial organizations.

The U.S. Qualification Standards establish the educational and experiential prerequisites necessary for actuaries to perform their roles competently. Complementing these standards is the Code of Professional Conduct, a set of ethical principles that all actuaries are required to follow. Of note is Precept #2 where actuaries are only entitled to practice in areas where they are qualified. The ASOPs provide essential guidelines that direct actuaries in their professional responsibilities. The ABCD plays a pivotal role in this framework, tasked with investigating complaints and offering guidance on professional conduct. They can make recommendations on disciplinary matters, but the actuarial organizations hold the ultimate decision regarding punishments for their members. The ABCD consists of nine persons who represent a cross-section of actuarial practice areas (currently three from Pension and two each from Life, Health and P&C.) They do not answer technical questions.

In its counselor role, the ABCD addressed 119 Requests for Guidance (RFGs) in 2023. Questions such as “How do I know if I am qualified?”, “When is a violation of the Code material?”, and “When should I make a complaint about another actuary?” are examples of the guidance they provide. RFGs by practice area are evenly distributed but vary by year. The ABCD has typically seen 100+ RFGs every year since 2017 (2022 had 96.) Prior to 2013, RFGs ranged from only 30-60 per year. Investigations into complaints and their resulting actions (expulsions, suspensions, and reprimands) taken against actuaries by the various organizations, including the Academy, Society of

Actuaries (SOA) and Casualty Actuarial Society (CAS) were shown. Again, this highlights the importance of accountability within the profession and our ability to self-regulate.

The session moves to address the complexities of navigating ethical dilemmas, posing critical questions that actuaries should consider, such as compliance, transparency, and the overall reputation of the profession. Being able to answer “Yes” to “Is it the right thing to do?” should always be paramount in our work. A detailed discussion of the Code of Professional Conduct follows, emphasizing its applicability to members of U.S.-based actuarial organizations and the necessity of remaining current with its precepts and annotations.

The U.S. Qualification Standards are explained in depth, outlining the educational and experience requirements for actuaries and underscoring the importance of compliance for maintaining professional qualifications. The ASOPs are presented as authoritative guidance for actuaries, detailing their purpose and structure while emphasizing the actuary's responsibility to be aware of applicable standards. ASOPs #1-Introduction and #41-Actuarial Communication apply to all actuaries. There are other cross-product ASOPs, like #23-Data Quality and #56-Modeling, and numerous practice-specific ASOPs. There are published Applicability Guidelines listed by practice area. While non-binding, they can help the actuary determine which ASOPs apply to their current task.

Several case studies are included to illustrate ethical dilemmas faced by actuaries, encouraging critical thinking about ethical decision-making and compliance with the Code of Professional Conduct. During the live session the panel led the audience through the first four cases before time ran out. The discussion was animated and led the audience to see real-world examples where specific precepts and ASOPs should be used to guide the actuary. The presentation concludes by providing a list of resources available to actuaries, including links to the ABCD website, professionalism webinars, discussion papers and other educational materials.

Session 403

Executive Compensation and Benefits from the Actuary's Perspective

Speakers:

- Joseph Adams – Winston & Strawn LLP
- Aaron Pedowitz, FCA, FSA, EA, MAAA – Mercer
- Alex Laun, ASA – Mercer

Moderator: David Scharf, FCA, EA, MAA - Gallagher

Session Host: Mellissa Lim – RGA

Background

Executive compensation and benefits are comprised of multiple elements extending beyond cash compensation. We focus on the primary objectives of three key compensation vehicles: short term incentives (STI), long term incentives (LTI), and deferred compensation, and how they form a strategic toolkit to incentivize, retain, and ultimately reward executives. In addition, other forms of executive benefits were reviewed, and lastly, we examined two key regulations that resonated with the audience: IRC 409A and top hat rules.

Short Term Incentives (STI)

Base salary is comprised of an annual cash salary determined by relevant market data for the position, skills, experience and performance of an executive. Short term incentives (STI) are cash awards based on achievement against predetermined annual goals and help to achieve tactical short-term performance within the period of one year. Cash compensation is comprised of both base salary and STI.

Design principles of a successful STI strategy involve 1) clear communication to eligible employees, 2) tying performance to three to five easily identifiable goals or metrics, 3) ensuring there are consistent terms and conditions with no ambiguity in administration, and 4) aligning STI design internally and externally to meet the needs of the organization and the market.

Although STI performance metrics can vary between companies, revenue and sales are typically the highest-ranked metrics used. Financial goals are the most important, while individual performance goals are usually the lowest importance. Financial goals can be used as a modified circuit breaker whereby any payout in the plan may be triggered by meeting a specific financial metric.

STI performance weighting typically varies by level, with higher organizational goal weighting for top executive levels. Weightings should be set to match each group's ability to affect the performance

measures attributed to them, and senior leaders directly influence the organization and financial outcomes. Thoughtful consideration should be put into STI payout thresholds, targets and maximum amounts. Executive compensation consultants can perform "realized pay analysis," a targeted review of goals vs. achievement. This analysis may assist a company in evaluating whether there is alignment between the board and management in selecting the appropriate metrics for evaluation.

Long Term Incentives

Long term incentives (LTI) are cash or equity awards based on achievement against a predetermined set of goals requiring a performance period of over a year. LTI is typically tied to executing and achieving a strategic plan and is used as a retention tool. The type of LTI offered by the employer will depend on the ownership structure of the company—whether the company is public or privately held.

At public companies, LTI is usually tied to equity, and employers want their executives to have their performance subject to the ups and downs of the share price. As a result, at public companies, it is more common to have LTI tied to real equity in the form of stock options, restricted shares, or performance shares. Usage of restricted and performance shares is more prevalent than stock options. Restricted shares consist of equity that vests over time, typically annual grants. Depending on the level of the executive, a company may have requirements to hold and accumulate a certain level of equity tied to a multiple of compensation ("stock ownership guidelines"). Performance shares are tied to the achievement of specific performance goals or targets and are reserved for the most senior executives.

At privately owned companies, it is more common to have LTI tied to cash in the form of stock appreciation rights, phantom shares, long-term cash, or long-term profit sharing. A privately owned company may develop a hypothetical stock price and offer incentives pegged to this hypothetical amount in the form of phantom shares or stock appreciation rights.

LTI performance metrics are typically tied to team and company-based metrics. The performance metric selected must be easily explainable to shareholders. Revenue is the leading performance metric used for evaluation.

Nonqualified Deferred Compensation Plans ("NQDC")

Deferred compensation is primarily used as a retention tool and is not typically tied to an employee's performance. NQDC allows executives to supplement their retirement income over and above qualified retirement plans. Most plans currently have a defined contribution ("DC") structure, allowing voluntary deferrals alongside annual contributions as a percentage of cash compensation. Participants delay receiving a portion of their compensation (salary, bonus, commission, RSUs, etc.), and/or the employer can match or make other contributions. At a predetermined future date, employers pay back the income plus accrued notional earnings. These benefits help executives accumulate wealth on a pre-tax basis and can support tax planning

strategies. NQDC immediately reduces payable income tax and helps executives accumulate assets to meet their financial goals.

NQDC plans typically fall into three categories: 1) Voluntary Deferred Compensation Plans, 2) Restoration Plans, and 3) Supplemental Executive Retirement Plans (SERPs). About 73% of companies provide nonqualified voluntary deferred compensation plans, allowing executives to defer pay on a pre-tax basis without IRS limitations voluntarily. The next most popular nonqualified option is restoration plans, which make up for the employee the value lost due to IRS limits in an underlying qualified plan with similar provisions. Lastly, and the least offered option, is SERPs, which are more generous than a restoration plan and provide benefits over and above the qualified formula. Enhanced SERPs are typically only provided to the most senior executives, primarily the CEO and their direct reports, and are an effective tool for executive recruiting and retention.

Other Benefits

Other executive benefits range from various forms of insurance (medical, STD, LTD, life insurance) and physical examinations to usage of company aircraft, car allowances, and personal security. Many companies have found that these additional benefits may be very valuable to the executive. Which of these additional benefits may be offered will depend on the company and industry. More recently, there has been a decrease in the number of perquisites offered.

Regulations

There are many different laws and regulations that focus on executive compensation and benefits. The audience was most interested in discussing IRC section 409A and Top Hat Rules.

IRC 409A governs the payment restrictions of nonqualified deferred compensation and defines timing requirements for making deferral elections. 409A applies to deferred compensation ("earned and vested" after 2004). Benefit payments can only be triggered by specific events such as a separation of service, a specific date, death, disability, change in control or unforeseen financial emergency. If a participant wants to push a deferral to a later date or change their form of payment, the change must be made at least 12 months prior to the original payment date. Additionally, the change will cause the payout to commence at least five years following the original payment date. There are significant consequences for impermissible accelerations or deferrals of NQDCs in violation of 409A, which assesses penalties against the participant, not the company.

Top Hat rules set eligibility criteria for establishing an unfunded nonqualified plan for select employees. Generally, Top Hat plans must limit participation to a small percentage of total employees where eligible participants have executive or managerial positions. The DOL has declined to offer specific numeric guidelines, and there have been multiple court cases brought by participants contesting the top hat status of a plan.

Session 406

Productivity, Project Management, and Talent Development in the Hybrid Workplace

Speakers:

- Ellen L. Kleinstuber, FCA, MAAA, FSA, EA, FSEA – Bolton Partners, Inc.
- Kelly Boschke, FCA, FSA, EA – Fidelity Investments
- Marcie Smith Gunnell, FCA, MAAA, ASA, MBA – Deloitte
- Jami Eckman, FCA, FSA, EA – Mercer
- Rodolfo Ernesto Garcia, FCA, MAAA, EA – Bolton Partners, Inc.

Session Host: Danielle Almeida, EA, MAAA – Gallagher

Overview

The migration to a hybrid work environment provides flexibility and opportunity for employers and employees. It also necessitates rethinking many of the aspects of how we manage work and develop talent. Speakers explore how consulting firms are using these issues as a springboard for innovating how we run the modern actuarial workplace.

Defining the Challenges and Benefits of a Hybrid Work Environment

As an introduction to the session, the audience was asked to provide one-word responses on both the largest hurdles and greatest benefits of a hybrid work environment. The word clouds are shown below in Images 1 and 2 for completeness.

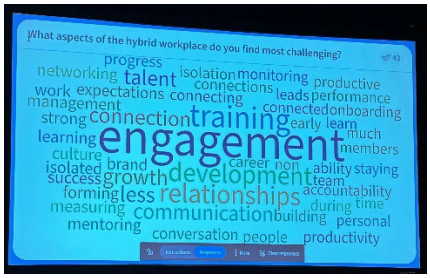


Image 1

Some of the most noted challenges were engagement, training, development, and relationships. Both the audience and panelist group expressed agreement that it is difficult to gauge and build engagement of the workforce in virtual environments. Audience participation included some feedback for ways to foster engagement in work settings (i.e., scheduling prep calls and debrief sessions and reserving time on calendars). To aid in training and minimize multitasking, it was suggested to schedule one on one time to share screens and to step through details and questions. With regards to development, it was discussed that feedback provided timely was most impactful for junior staff. Lastly, a panelist noted that accountability is not often listed as a primary concern,

but often appears in situations where there is a lack of productivity in a remote environment. **Fostering communication with employees and setting clear boundaries were suggested as ways to improve concerns related to accountability. In summary, intentionality was the most common theme to help abate these concerns.**

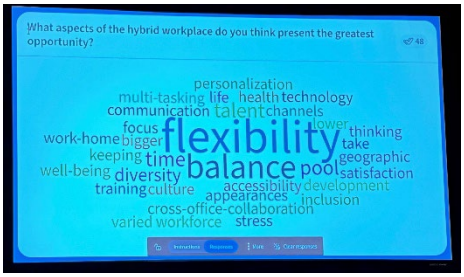


Image 2

The second word cloud was used to highlight the greatest opportunity afforded to employees and employers when considering the hybrid work environment. **The main takeaway is that the flexibility associated with a hybrid work environment allows for personalization of the work experience and increases the employee's ability to balance time.** The inclusion of the term balance in the word cloud garnered additional feedback from the audience that balance is an individual definition and is a practice that requires discipline. The panel noted that separating time into buckets is helpful in some cases, such as scheduling one day a month to think through ideas and considerations without other distractions. Accessibility for a wider network was unanimously voted as an opportunity, both for individual success as well as for recruiting diverse talent.

Intergenerational Differences

The audience noted that intergenerational differences were evident especially in context to how each generation approaches the hybrid work environment in relation to work-life balance and flexibility, as shown in the polling result in Image 3 below. Because of the consistent use of technologies, the younger generations tend to adapt more quickly to changing technology and expectations in a hybrid environment. The audience was polled, and the prevailing generation represented in the room was Millennials (birth years 1981 – 1996).

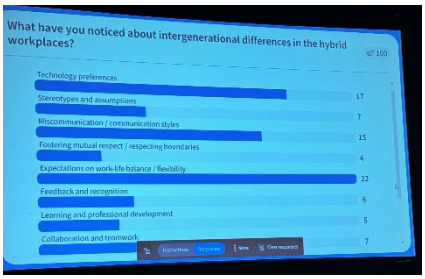


Image 3

Discussion from audience members indicated that they find members of differing generations have a challenging time empathizing with the desires of workers from other generations (i.e., younger

unmarried employees wanting work/life balance as opposed to leaning into career opportunities that may require heavier time commitments). “Off-hours” working was noted as another point of contention intergenerationally. Some workers finish their days into the evening but are not expecting others to follow their lead. **An important aspect of virtual working is to set expectations on working hours for team members to facilitate training and collaboration opportunities.**

Managing and Developing Talent in a Hybrid/Remote Workspace
Many components go into developing talent in a hybrid workplace, but they all center on addressing individual needs and preferences to optimize the investment of time from both an employee and employer perspective. Recruiting talent can yield a wider net when the job is remote but could also be a detriment to an employee looking for an office-based culture. Bias should be considered when fostering the corporate culture.

Supporting actuarial exams for employees still in the process should focus on making sure that the employees are supported to take their allocated time in the corporate exam programs. Often, it’s not as easy to study independently, so a suggestion was made to have virtual study groups for employees that are not local to colleagues taking the same exams.

Building consulting skills can be fostered in a hybrid work environment by allowing junior staff to attend virtual meetings with clients more frequently than they may have been given an opportunity for an in-person meeting. This ensures our clients are aware of the many consultants servicing their accounts and allows junior staff to witness the client interaction with more senior colleagues. **It was noted as most important to model good consulting skills as most people learn by example.** (And make sure to always have a backup plan in case technology fails.)

Managing relationships is easiest with visual cues. If in-person collaboration is not an option, video conferencing to connect with employees and best nurture those relationships is ideal.

Networking: Building and Navigating Corporate Culture
When a subset of the workforce is remote, it is important to build community in other ways. Suggestions from the panel and the audience included a monthly meeting for those employees not headquartered out of a hub and building time into calendars to chat. It has been effective for some to replicate what would have been “water cooler” conversations by encouraging all team members to schedule time on calendars to catch up socially.

Another suggestion included intentionally allowing time to meet with colleagues during travel. For example, if an employee is attending a client meeting in a city that has an office location, encourage them to allocate time to connect in person.

Lastly, time zone differences were noted as a point of consideration for all to keep at the forefront of remote work, especially if those you work with are spread geographically.

Productivity and Project Management

The main concept that centers the hybrid work environment is to work smarter, not harder. Communication and intention are the keys to success in a hybrid environment. Employees should attempt to minimize distractions, wherever the hybrid work environment may be. Make alternate plans for technology glitches.

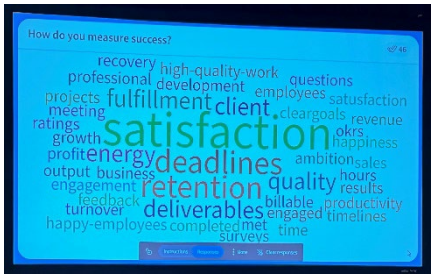


Image 4

Image 4 summarizes the final word cloud presented and asked the audience to define how success is measured in a hybrid workplace. **This word cloud had the most diverse set of responses from the audience which included assessing success based on client outcome/retention as well as assessing success based on employee retention. It was clear there are various definitions of success, which may all be used in conjunction.** Even the most used word, satisfaction, garnered some debate from audience members, further supporting that this is a multifaceted assessment that cannot be drilled down to a single measure.

Session 407

ADC versus Fixed Rate Plans and Other ASOP 4 Issues

Speakers

- Matthew Strom, FSA, MAAA, EA – Segal
- Koren Holden, FCA, MAAA, EA – Colorado PERA
- Elizabeth Wiley, FSA, FCA, MAAA, EA – Cheiron

Session Host: Geoff Bridges, FSA, FCA, MAAA, EA – Segal

Discussion of the Spectrum of Contribution Approaches

The determination of the annual funding amount for public sector plans falls on a continuum. On one end of the continuum are plans with contribution rates fixed by statute. On the other end of the continuum are plans with contribution requirements based on an Actuarially Determined Contribution (ADC).

For fixed rate plans, important considerations are funded percentage, projected trend, and comparison to a benchmark ADC. Considerations for ADC plans include the amount of the contribution, annual volatility, and affordability.

There are plans that fall in between the extremes. Some fixed rate plans have rates that are difficult to adjust. For example, only the state legislature can change the rates (case in point, North Dakota Teachers). Other plans have rates that can be adjusted by the plan's board, often with legislative oversight. (Examples: Vermont Municipal Employees and South Carolina Retirement System.)

Further along the spectrum are plans with fixed rates with automatic adjustments. (Examples: Colorado PERA and South Dakota Retirement System.)

The next step on the continuum is plans that use an ADC but with automatic changes (such as increasing the ADC by a fixed percentage). (Examples: Wyoming Retirement System and Indiana PERS.)

There are plans that calculate a funding requirement similar to an ADC, but the methods don't satisfy the requirements of Actuarial Standards of Practice No. 4 (ASOP 4) for an ADC – for example, the funding method may target 90% funding rather than 100% funding. (Examples: a number of plans in Illinois.)

Plans that use an unadjusted ADC include the New Hampshire Retirement System and Vermont State Employees & Teachers.

Poll #1 – Do/did you work on any public plans characterized as a Fixed Rate Plan or Statutory Rate Plan: 56% - yes (currently), 18% - during career, 23% - never.

Poll #2 – Does the fixed rate in #1 allow for variance of the fixed contribution rate/amount: 32% - yes, 64% - no, 4% - it's complicated.

Poll #3 – Do/did you work on any public plans categorized as an ADC rate plan: 80% - yes (currently), 18% - during career, 7% - no.

One public plan that applies a "sticky" mechanism to the calculation of the funding requirement is essentially using a form of output smoothing.

Poll #4 – Does the ADC rate plan from #3 limit increases or decreases in the ADC rate/amount: 28% - yes, 68% - no, 4% - it's complicated

Employee contributions are a consideration in the funding policy. One issue in particular: some plans have higher employee contributions than normal cost.

Case Study – Colorado PERA

Colorado PERA is a statutory rate system with automatic adjustments. The system has gone through two significant reform efforts related to funding in the last 15 years. One major reform measure enacted in 2018 implemented an Automatic Adjustment Provision (AAP) mechanism.

If certain metrics aren't hit in the AAP assessment, changes are triggered to the member and employer contribution rates and the Cost of Living Adjustment (COLA).

The three smaller Colorado plans are tied to what is happening in the larger plans due to the use of blended rates in the AAP assessment. So, it is possible that one of the smaller plans could be near or over 100% funded, but adverse experience in the larger plans could trigger a contribution rate increase and a COLA decrease.

Poll #5 – Do/did you work on any public plans with other unique funding structures or policies: yes - 36%, no - 64%.

One plan, for example, pays 105% of the ADC if less than 100% funded. Once it hits 100%, they pay 100% of the ADC. Amortization is 20 years.

Implications of the Actuarial Standards of Practice

ASOP 4 has implications for the contribution allocation procedure (CAP), which we also refer to as the funding policy. As part of a valuation, an actuary should qualitatively assess the implications of the CAP on projected contributions and funded status. If negative amortization is anticipated, estimate the period that the negative amortization will last. Estimate the time until the unfunded

liability is fully amortized. Determine if the CAP is inconsistent with accumulating sufficient assets to pay benefits when due.

For these assessments, consider whether it is more appropriate to use the market value of assets or the actuarial value of assets.

Poll #6 – Do you work on public plans that have incorporated additional analysis related to amortization due to the requirements of ASOP 4, Section 3.19: 6% - yes, 90% - no, 5% - no but considering.

Poll #7 – Do/did you work on any public plan that uses a form of output smoothing: Yes – 56%, no but would consider - 44%

It is common to phase in the impact of assumption changes. Illinois sometimes phases in over a period that is longer than the period to the next assumption study.

Comparing an ADC to fixed rates: in some plans, if the effective amortization period is less than 30 years, the fixed rate is an ADC; otherwise, disclose that the ADC is greater than the fixed rate contribution.

Poll #8 – Did any of the public plans you work on need to develop a reasonable ADC or revise an existing ADC due to the recent revisions to ASOP 4: Yes – 14%, no, but revised anyway – 5%, no – 82%

Poll #9 – Have any of the public plans you work on incorporated a Low Discount Rate Obligation Measurement (LDROM) in funding policy: 4% - yes, 96% - no.

Some plans use a low discount rate (lower than the LDROM rate) but not the LDROM metric.

Session 505

Current Topics in Medicare Advantage, Part D, and the Inflation Reduction Act

Speakers:

- David Tuomala FCA, FSA, MAAA – Optum
- Ward Brigham, FSA, MAAA – UnitedHealthcare
- Steven Draper, FCA, FSA, MAAA, EA – Ernst & Young, LLP
- Dan Hoffman, FCA, FSA, MAAA - Optum
- Jennifer Carioto, FSA, MAAA - Milliman

Session Host: Sarah Rothenberg, FCA, FSA, MAAA, EA - Empower

Background

Speakers highlight current topics in Medicare Advantage and Part D, and changes to the programs due to the Inflation Reduction Act. Topics include Medicare Advantage, Medicare Part D, employer sponsored Medicare plans, and OPEB valuation issues.

Employer Group Market

Employers who offer retiree medical coverage for Medicare eligible participants are offering Medicare Advantage (MA) plans with increasing popularity due to the lower retiree costs, lower employer costs, better coverage options, and simpler administration.

Despite their popularity, these plans are facing challenges. The risk score model is undergoing changes which began in 2024 and will continue through 2026. Additionally, there have been upticks in outpatient surgeries and inpatient services due to the delayed impacts of COVID-19 and the enforcement of the two-midnight rule which became effective in 2024 for MA plans. There are some stresses on Medicare Part D as well due to the Inflation Reduction Act (IRA) which is leading to richer Part D benefits, along with the increasing popularity of drugs such as GLP-1s which are further adding to costs.

Employers have options that may help mitigate these concerns. They may negotiate with carriers to employ multi-year rate guarantees or gain share agreements, consider changes to plan designs such as adding Part D deductibles, they may move to fixed retiree subsidies, and/or split their Medicare Advantage Prescription Drug (MAPD) plans into MA-only plans combined with Prescription Drug plans (PDPs) to take advantage of CMS's Premium Stabilization Demonstration. Despite these new challenges, MA plans remain a strong option for employers, allowing them to offer richer benefits than are available in the individual marketplace at a reduced cost compared to other coverage options.

OPEB Valuation Issues

There are certain considerations that should be taken when setting OPEB valuation assumptions. Of utmost importance in any valuation is making sure that all assumptions are clearly explained in the

valuation report. For example, trend for a year should specific whether it is the trend to the next year or trend rate from the prior year. When evaluating the healthcare trend assumption, it is important that the actuary consider the leveraged nature of healthcare costs which is particularly prominent in MA plans. Ideally, the actuary will get the full MA renewal to understand how CMS and other offsets are being accounted for in the premium calculation. The actuary will want to consider how each component will trend when setting the healthcare trend assumption. Additionally, if the claim cost was set at the beginning of the year, the actuary should incorporate premium renewals and either create a new claim cost at year-end or use the actual trend for the year when calculating year-end claims so as not to be relying on outdated information.

When evaluating the impact of the IRA, it is important that the actuary document each consideration and not simply say that there are too many unknowns. Plan sponsors and actuaries should also consider how the $2,000 true out-of-pocket limit (TrOOP) will impact EGWP (Employer Group Waiver Plan) plans and should be aware that plans who offer benefits that are richer than standard Part D benefits may find that these plans will become even richer under the IRA in 2025 since these additional benefits will count towards the TrOOP.

Medicare Part D

The risk score model is changing in 2025 to account for the increased plan liability as part of the impact of the changes from the IRA. CMS introduced in 2025 a separate risk score normalization factor between MAPD and PDP plans because there is a difference in risk scores between MAPD and PDP that are believed to be from MAPD's incentive to submit more diagnosis data. It is expected that there will be an increasing divergence in risk scores between MA-PD and PDP plans as there will be an increased incentive for MAPD plans to increase coding initiatives. Due to differences in normalization factors, the risk scores for PDP plans will be higher than for MA-PD plans assuming a member with the same RxHCCs. The direct subsidy has skyrocketed in 2025 due to the IRA changes increasing plan liability. The low-income premium subsidy amounts (LIPSAs) have on average increased in 2025 but due to regional differences the LIPSA amount varied significantly. Finally, CMS created a PDP voluntary demonstration program to limit Part D premium changes. The details of the program were released after rates were set and it is expected that the majority if not all PDP plans will take advantage of this program. The program increased the direct subsidy by $15 PMPM, capped premium increases by $35 PMPM, and provided further protection to plans through enhancements to the risk corridor program.

IRA Price Negotiation

The IRA authorizes the HHS Secretary to negotiate maximum fair prices (MFPs) for single source drugs and biologics in Medicare Part B and D. The number of drugs that can be negotiated will increase over time with only Part D eligible for negotiation in 2026 & 2027, Part B eligible beginning in 2028, and additional drugs eligible beginning in 2029. Drug eligibility is based on many factors including a drug's launch date and current gross spend. The negotiated price considers several things such as how long the drug has been on the market and average net prices. All drugs that are

being negotiated must be included in Part D formularies to allow Medicare beneficiaries access. Drugs on the negotiated list for 2026 represent 20% of Part D costs.

Negotiated drugs will not be subject to the Manufacturer Discount Program (MDP) and it is unlikely that manufacturers will pay supplemental rebates due to the discounted MFPs. For drugs who currently have low or no rebates, the MFP likely will result in plan savings, but for plans with large rebates it is possible that the MFP will be more expensive for the plan. Plans may adjust their formularies to steer utilization towards the cheaper negotiated drugs. Additionally, we are waiting on guidance on how pharmacies will be compensated for these negotiated drugs since under the current model pharmacies would purchase negotiated drugs at the WAC price but dispense them at the discounted MFP.

Session 601

Small Plan Terminations – PBGC and Non-PBGC Plans

Speakers:

- Justin F.J. Greindl, FSA, EA, MAAA, MSEA - Fidus Actuarial Solutions
- Meredith J. Sesser, Esq. - Meredith J. Sesser, A PLC
- Lance Roteman, FCA, EA, MAAA, MSPA - National Professional Planning Group

Session Host: David M. Davala, FCA, EA, MAAA, MSPA - Trinity Pension Consultants

To kick off the topic, the speakers asked attendees about their experience with plan terminations. Most had navigated at least one plan termination, giving us a wealth of practical expertise in the room. Below are some of the key takeaways from the session.

- High-level considerations before terminating a plan
    - Plans have become fully funded recently due to the rising interest rate environment. Becoming fully funded might cause a plan sponsor to consider termination.
    - Consultants should consider whether the primary purpose for the plan is an employee benefit or the owner's retirement plan. The role the plan plays will help inform whether the appropriate strategy for the plan sponsor will be to terminate or hibernate the plan.
- Terminating underfunded plans
    - In some cases, plan sponsors might negotiate a distress termination with the PBGC.
    - The PBGC may initiate an involuntary termination of the plan in some circumstances.
    - Majority owners can elect to forgo a portion of their benefits, which can facilitate the termination of underfunded plans. However, "majority owner" is defined as owning 50% or more of the company, which may be limiting. If there is no majority owner, ownership options can be used to create them. For example, there are three individuals who each own 1/3rd of the company. They can each sell an option to purchase 20% of the company to another owner. Each owner owns more than 50% of the company when the options are added.
- Standard terminations
    - The standard process typically takes 60-90 days.
    - For plans still accruing benefits, ERISA section 204(h) notices must be distributed 45 days before the effective date of the amendment. The period changes to 15 days for small plans.
    - Coordination of responsibilities is critically important to successful plan termination. A panelist recounted a situation that became needlessly complicated because the final government filings for the plan were not completed in part because it wasn't clear who was responsible. The PBGC became involved and was very intrusive in the affairs of the company.

    - Be sure to show assets that are sufficient for liabilities on Schedule EA-S of PBGC Form 500 to avoid unnecessary questions from the PBGC. Most attendee actuaries require a waiver or commitment to fund signed by the sponsor before signing the EA-S
    - Consider whether filing for a determination letter is beneficial. The process is expensive and generally lengthy.
    - During the PBGC review period, you can keep the normal pay out process. For example, if you have been paying out terminated vested soon after termination, then you can keep doing that.
    - Make sure to answer all PBGC questions to avoid the PBGC not considering the termination final.
    - If PBGC has a lien on sponsor assets, the PBGC will not release it until the review period is over.
    - PBGC audits may not commence for quite a while following plan termination. One attendee had a case where the PBGC audited the plan five years after the termination.
    - For plans with outstanding loans, it may be best to transfer to a defined contribution plan if possible.
- Excess assets
    - If ERISA Title IV applies to the plan, amendments affecting reversions or surplus assets that may be reverted require a five-year waiting period.
    - For significantly overfunded plans, note that there are companies that may buy the plan. Most of the time there is not much cost difference between the reversion excise tax and the discounted value of the trust assets in the sale.

Session 602

Successfully Working with the PBGC

Speakers:

- Matt Fishel, FCA, FSA, EA – Mercer
- Israel Goldowitz, Esq. – Wagner Law Group
- Katherine Kohn, Esq. – Thompson Hine LLP

Session Host: Gail Steward, FCA, EA – USI Consulting Group

Note that 2025 PBGC premiums are accelerated by 1 month by the Bipartisan Budget Act of 2015! For calendar plans the premiums are due September 15, 2025, not October 15, 2025!

Background and current environment

All covered DB plans interact with the PBGC on at least an annual basis because of the required PBGC premiums. The PBGC single-employer fund surplus has grown to $44.6 billion at the end of FY2023. PBGC's estimate of its single-employer reasonably possible losses also fell significantly year-over-year, a 51% reduction to ~$25 billion as of fiscal year-end. The PBGC's multiemployer fund surplus is $1.5 billion and is likely to remain solvent for 40 years.

Bankruptcies were down the last few years due to pandemic relief but are starting to rise again. Also, M&A activity has slumped, but there is a pent-up demand.

Rising interest rates have eroded the impact of the funding relief interest rates, so more plans might be required to contribute cash to their pension plans or possibly apply for funding waivers.

Recent Inspector General audits of Special Financial Assistance have found no significant errors (like paying deceased annuitants).

There are calls from multiple sources to provide premium relief while the PBGC programs are at a surplus – especially for single-employer plans. There are also calls to take the PBGC premium income off budget since it cannot be used for anything other than paying participants. However, the current budget committee is not interested in taking it off budget, so that could be an uphill battle.

New ERISA 4044 assumptions

Effective for valuation dates on or after July 31, 2024, the interest assumption uses a yield curve approach derived from 2/3rds corporate bonds and 1/3rd Treasury bonds, which should increase

transparency. The mortality tables are now generational. These assumptions are used for distress termination applications, termination and mass withdrawal liabilities, PBGC 4010 liabilities, Missing Participant transfer amounts and spinoff calculations for Section 414(l) of the IRC.

Legal Updates

The Supreme Court's June 2024 decision in *Loper Bright* eliminates *Chevron* deference, under which courts generally were required to defer to an agency's reasonable interpretation of a vague or ambiguous statute. The same day, the Supreme Court issued its decision in *Corner Post*, clarifying that the 6-year statute of limitations under which a party may sue an agency under the Administrative Procedure Act (APA) begins to run when the plaintiff is harmed, not when the agency issues a regulation. These twin decisions could impact PBGC regulations that deal with challenges to withdrawal liability calculations for multiemployer plans that received Special Financial Assistance (among many others).

Standard Terminations

The increase in the threshold for an automatic audit (from 300 to 1,050 participants) has not changed the overall volume of audits. PBGC may be able to assist small plans with finding an insurer to take the benefits at plan termination. Common errors uncovered upon audit include accrued benefit calculation errors, lump sum calculation errors, failure to obtain proper elections and spousal consents, and failure to include all optional forms provided by the plan on election forms and/or in the annuity contract.

Note that lump sum windows done in connection with plan terminations are subject to PBGC audit. SECURE 2.0 requires plan administrators to provide additional disclosures when offering a lump sum window outside of plan termination, effective after the DOL and Treasury publish regulations, which will include a model participant notice.

Distressed Plan Issues

Funding waivers require the applicant to submit considerable documentation establishing that the sponsor's business hardship is temporary. Waivers are simply a re-amortization of the contributions being waived. These could impact business loans since the funding waiver is usually considered a default by the sponsor.

There are many consequences of missed contributions (see the session handout for a table discussing them). Note that the PBGC files liens for missed contributions in excess of $1 million.

PBGC might take the plan, but there are many steps to go through before that happens. It is slightly easier if the sponsor is in bankruptcy. Note that if the sponsor is part of a controlled group, the proof is more complicated and more difficult.

Reporting

4010 reporting is required if any plan in the controlled group has a 4010 FTAP < 80%, if there are missed contributions of $1 million or more, or if any controlled group plan was granted one or more funding waivers totaling $1 million or more, and any portion remains outstanding.

Reportable event filing is required for certain plan events (such as active participant reduction) and for certain corporate events (such as a change in the controlled group). Some events require advance notice, while others require notice after the event has happened. Refer to the PBGC website for full details.

Session 604

Healthcare Trends and Forecasting in a High Inflationary Environment

Speakers:

- Katie Martin, MPA – Health Care Cost Institute
- Liz Kochneff, FCA, PhD, FSA, MAAA – Alight
- Ivy Dong, FSA, MAA – Wakely Consulting Group
- Wayne Pages, FCA, ASA, MAAA – Marsh McLennan Agency

Session Host: Piotr Krekora, FCA, ASA, MAAA – Gabriel, Roeder, Smith & Company

Overview

The healthcare industry continues to experience cost pressures in excess of general inflation. In this session, the speakers attempt to identify key drivers behind the recent trends in healthcare costs and discuss their near-term impact on consumers, insurers, and other stakeholders.

Historical view of main factors behind changes in healthcare costs

Based on commercial claims data from the Health Care Cost Institute (HCCI) covering approximately 50 million lives, per person healthcare spending grew approximately 18.7% from 2018 through 2022. In broad terms, healthcare spending is often decomposed between utilization (or use) and price. Other commonly analyzed factors are demographics and case mix. Prices have been the primary driver of the growth in gross spending, accounting for approximately 14% with the remaining 4% attributed to increased spending. Demographic distributions remained relatively stable with very little net impact on the cost changes over the study period, while case mixes had a small decreasing effect on both the utilization and the price which is reflective of a shift towards less complex and less expensive treatments and procedures. It is worth noting that while overall spending during 2020 was down from 2019, owing to a drastic decrease in utilization, total spending for 2021 and 2022 was in line with pre-pandemic trends.

While general inflation has a major impact on changes in healthcare prices, healthcare cost also affects inflation, making it difficult to isolate the role of inflation. Nevertheless, data from the Bureau of Labor Statistics (BLS), as compiled by the Kaiser Family Foundation (KFF), shows healthcare costs outpacing general inflation in most pre-pandemic years since 2000, with the price of medical care, including services provided as well as insurance, drugs, and medical equipment, increasing by 121.3% from 2000 through 2024, while prices for all consumer goods and services rose by 86.1% in the same period.

Three structural factors can explain some of the price increases: decreased competition resulting from higher market consolidation activity (the majority of providers and hospitals in a given area are associated with just one or two organizations), increased facility fees caused by shifting the site of

service from independent offices or laboratories to hospitals, and increased private equity acquisitions.

Impact of Trends on Individual Markets

The analysis of the individual health insurance market can be divided into broad categories: pre-Medicare and Medicare. While the health insurance market for Medicare-eligible individuals has been growing steadily for a few decades, the pre-Medicare counterpart exploded in 2014 when provisions of the Affordable Care Act ("ACA" or "Obamacare") took effect. Affordability is a key government priority to combat healthcare costs in both markets.

Pre-Medicare individual insurance participation increased particularly amongst lower-income individuals and families due to substantial governmental premium subsidies as well as amongst individuals with preexisting conditions, who couldn't get coverage prior to ACA. Enrollment increased from 8 million in 2014 to over 21 million in 2021. It is worth noting that governmental premium subsidies have the effect of insulating lower-income consumers from actual healthcare prices as they are typically driven off income rather than the prevailing cost, and are higher in more expensive areas further reducing differences in premiums actually paid between regions. This effect spilled to other income groups upon implementation of the American Rescue Plan Act in 2021 as extended by the Inflation Reduction Act.

Average total premiums had been increasing through 2019 followed by small decreases through 2022 (believed to be a combination of COVID impact and a rollback of pre-2019 overcorrections) and increased after that reaching 2019 levels for 2024. Total premiums are projected to increase a little faster for 2025 and 2026 primarily due to utilization of diabetes and obesity medications (commonly referred to as GLP-1) and hospital consolidations. Income-related premiums dropped substantially in 2021 due to increased government premiums. It was more dramatic in nominal terms for individuals with incomes at 400% of the Federal Poverty Level (FPL) who paid unsubsidized premiums in 2020 but only approximately 60% of a full premium in 2021. Lower-income individuals (represented by 250% of FPL) paid approximately 30% of premiums in 2020 dropping to 15% for 2021. Increased subsidies are scheduled to sunset after 2025 which, if it happens, will result in substantial increases in premiums actually paid by covered individuals. Furthermore, if subsidies are not extended, smaller insurers are likely to exit the market resulting in additional premium increases.

The insurance market for Medicare-eligible individuals currently covers approximately 40 million individuals nearly equally divided between Medicare Supplement (Medigap) products and Medicare Advantage Prescription Drug (MAPD) plans. Medigap plans are medical products designed to wrap around Traditional Medicare and require a separate subscription in a Medicare Part D plan (PDP). MAPD plans, on the other hand, are designed to replace the Traditional and Part D Medicare. They tend to be more managed than supplemental plans with more cost controls. Many of MAPD plans feature a $0 premium which increases the difficulty of analyzing trends in consumer cost. For a better comparison between plans, analysis often combines

premiums with out-of-pocket expenses (OOP). Based on data from Alight's retiree exchanges, the cost for supplemental plus PDP insurance increased steadily between 2019 and 2024 at an average rate of approximately 3%. At the same time, the cost of MAPD coverage had been decreasing at an average rate of approximately 3.3% and is now less than half of the cost of a Medigap plan with PDP added. Costs for both groups are projected to increase for 2025 and 2026 but Part D changes (lowering pharmacy out-of-pocket to $2,000) will have a dampening effect for 2025.

Value Based Care Impacts

Value-based care has been enjoying an increasing presence across all markets. Value-based payment (VBP) models garnered attention from both the government administration and private equity investors.

Centers for Medicare & Medicaid Services (CMS) as well as private investors participating in Health Care Payment Learning & Action Network (HPC LAN) have goals of moving providers towards value-based payment projects. One of the avenues is the acceleration of tying US healthcare payments to quality and value. HPC LAN data shows increasing adoption of Value-Based payment models across all lines of business, with the most success in MAPD markets. Interestingly, commercial markets are lagging behind both MAPD and Medicare fee-for-service. CMS aims to provide all Medicare and half of Medicaid coverage through Accountable Care Organizations (ACO) by 2030. They utilize two payment models: Medicare Shared Savings Program (MSSP) and ACO Realizing Equity, Access, and Community Health (ACO REACH). Both models experienced promising success and currently affect care for approximately 13.5 million beneficiaries (10.8 million through MSSP and 2.6 million through ACO REACH). CMS proposed changes to all VBP models. Changes proposed for REACH ACO will make it more difficult for these groups to reach their financial targets forcing them to look for efficiency improvements. MSSP changes, among other items, aim to soften the current benchmark design penalizing ACOs for their good past performance. The new Part D score model and MAPD star ratings are expected to increase uncertainty and increase pressure on insurers to improve efficiency.

Commercial Markets Trends

A recent study analyzed trends in cost experienced by a book of self-funded plans from January 2020 through June 2024. The medical and prescription study was based on nationwide (but dominated by East Coast clients) experience and focused on the allowed gross amounts before any rebates, stop-loss reimbursements, or cost-sharing adjustments.

The main observation is that the increases over the recent post-pandemic period were similar to historical norms. The annualized Med/Rx PMPM trend for the most recent two-and-a-half-year period averaged at 6.68% per annum, with upward pressure coming mostly from pharmacy experience, mainly diabetes and obesity (GLP-1) medications.

Going forward, gross pharmacy prices are expected to increase for 2025 by approximately 10% to 12%, accompanied by medical increases between 6% and 8%. Plan sponsors may want to look for ways to dampen those trends, for example, discourage members from overutilizing emergency rooms and monitor other high-cost utilization patterns.

A dental and vision cost study analyzed data from the West Coast area and was based on gross claim lags. Dental cost trends have been declining in the post-pandemic period but stayed positive and averaged at 1.46% per annum. At the same time, vision trends also followed a declining pattern but were lower than dental, often negative, averaging at -2.13% per annum.

Conclusions

Healthcare costs have been increasing except for a short period during the COVID-19 pandemic. Although further increases are expected, there are major efforts to control those increases, most notably by employing value-based payment models.

Session 606

Lessons Learned From Starting and Running a New Consulting Business

Speakers:

- Adrienne Lieberthal, FCA, FSA, MAAA, EA, CERA – Athena Actuarial Consulting
- Donna C. Novak, FCA, ASA, MAAA – NovaRest Actuarial Consulting
- Justin N. Hornburg, FCA, FSA, MAAA – Justin Hornburg Consulting
- Rob Bacher, FCA, FSA, MAAA, EA – RBC Total Rewards and Actuarial Solutions

Moderator: Derek N. Guyton, FCA, FSA, MAAA

Session Host: Jolene Roe – Deloitte Consulting

Overview

While the dream of starting your own consulting firm can be very attractive, many consultants have found that they have encountered unexpected or surprising issues. In this session, speakers introduce themselves, their firm and cover the most critical challenges they have faced with their own firms.

Adrienne Lieberthal, Athena Actuarial Consulting

Adrienne Lieberthal founded Athena Actuarial Consulting in 2020, establishing a team that has since grown to about 25 employees working across both health and retirement sectors. Before launching her firm, Adrienne worked at large consulting firms, Deloitte and WTW, but the heavy travel demands and shifting strategic priorities led her to seek greater control over her career through entrepreneurship. With no major financial ties, Adrienne saw this as the perfect opportunity to start her own company, aspiring to foster an inclusive and supportive culture where employees could thrive. She committed to giving it two years, figuring that, at the very least, it would be a valuable learning experience.

Although Adrienne initially worried that she wasn't as far into her career as she would envision for this major step, she knew her strengths in relationship-building and business development would help her succeed. However, some unexpected challenges arose, including managing cash flow—securing a line of credit from banks proved difficult without an established rapport, and the timing of client payments didn't always align with payroll. Recruiting talented staff was also a hurdle, but the "Great Resignation" worked in Athena's favor. Building the right team quickly enough to keep up with Athena's strong pipeline of work was challenging, and managing payroll taxes across multiple states added complexity. In Athena's early years, Adrienne led most projects herself, but as the firm grew, she brought on two partners, hired an executive assistant, HR manager, and invested in IT and infrastructure. Today, Adrienne's challenges include navigating a fully virtual environment, diversifying revenue streams, and managing administrative and sales functions effectively.

Donna C. Novak, NovaRest Actuarial Consulting

Donna Novak founded NovaRest Actuarial Consulting in 2002. She currently has 5 fulltime employees and 5-8 part-time employees that focus on health insurance consulting. Donna was a Principal at Mercer/Oliver Wyman when she made the change. She started her career at CNA where she designed computer systems, taught computer programing, and programmed insurance computer systems. She has experience at Mercer, Deloitte, and Blue Cross Blue Shield Association where she provided health insurance consulting services. Through her career she played an active role in the SOA, AAA, and CCA. Through her experience she had an extensive network of insurance experts when she founded NovaRest. When 9/11 hit, Donna felt she needed a different direction. She believed that her entrepreneurial spirit was being discouraged at her current firm and that this was the right time to start her own firm. She had no fears, however some of the unexpected challenges she faced included, working in a home office resulted in being in the same space 24/7, paying payroll taxes over the internet, and staffing for administrative services. Due to her experience with overstaffing at other firms, Donna is a big believer in using sub-contractors during peak project times. One of Donna's current challenges is what billing rates to use in proposals and an unlevel workload during the year at NovaRest. Donna is also finding it challenging to recruit a senior partner to help manage NovaRest, grow the business, and allow her to take extended vacations with her retired husband.

Justin N. Hornburg, Justin Hornburg Consulting

Justin started Justin Hornburg Consulting twice, first in 2007 (ceased 2010) and then again in 2021. His firm focuses on Group Ancillary Products. During the 2010 to 2021 period, he was a full-time employee at a prior client of his, Alliant/American Benefits Consulting (ABC). Before Justin Hornburg Consulting, Justin was working at MetLife, largely focusing on jumbo groups in the automotive industry. The main reason Justin began his own firm (both times) was philosophical differences with management. He had been receiving great leadership training but felt he wasn't allowed to apply some of what he was taught.. Coincidently, managing people isn't Justin's favorite thing, so employing only himself has been great. He has partnered with other firms when he wasn't qualified on his own. Initially, he didn't have any concerns or fears about going out on his own, but he was naïve the first go around and had more concerns when the firm was restarted. After restarting his firm he began to question the decision because he wasn't hired right away which concerned him and his wife, so it's key for anyone wanting to pursue this route to have your spouse on board. Some of the initial unexpected challenges he faced were the fear of selling, imposter syndrome, data security, and conflicts of interest. His current challenges include, managing workload, managing clients' expectations, and keeping track of hours.

Rob Bacher, RBC Total Rewards and Actuarial Solutions

Rob founded RBC Total Rewards and Actuarial Solutions in 2020, operating as a solo entrepreneur. His career began in Canada, consulting at WTW, where he specialized in employee benefits, both domestic and international, pension asset management and de-risking. Rob moved to the US and overtime broadened his consulting focus into health benefits, total rewards and mergers and acquisitions. In 2010, he transitioned to corporate, holding several different HR leadership roles in

compensation and benefits. Before becoming an actuary, Rob attended business school, making the leap to starting his own firm a natural progression. Driven by a desire to provide value without commoditizing his skills, Rob embarked on his entrepreneurial journey. Early projects included advising an Australian firm with a healthcare point solution looking to enter the US market, supporting the new CHRO of a start-up scaling from 25 employees to 1,200 through 8 acquisitions and setting up their own inhouse HR capabilities, acting as interim head of total rewards and consulting with large private equity companies.

Rob faced initial fears about building his brand and establishing his reputation to secure work. Unexpected challenges included navigating the COVID-19 market environment, finding new opportunities, and dealing with imposter syndrome. Another challenge was determining his area of focus, given his extensive career experience, though his passion lay in big-picture total rewards and helping companies attract and retain talent. Operating without employees was not an issue for Rob, as he was often brought in to lead efforts and provided with a team upon onboarding. Today, his main hurdles include working in a fully virtual environment, which limits personal connections, determining appropriate billing rates for proposals, and balancing prospecting for new clients and projects while delivering on current commitments.

Session 607

OPEB Funding

Speakers:

- Joe Kropiewnicki, FSA, EA, MAAA – Deloitte Consulting LLP
- James J. Rizzo, FCA, MAAA, ASA – Gabriel, Roeder, Smith & Co.

Session Assistant: Linda L. Bournival, FCA, FSA, EA, MAAA – KMS Actuaries

This session may have very well been entitled "To Fund or Not To Fund" as many governmental entities question whether the municipality should be prefunding to an OPEB Trust at all. The presentation noted several issues that should be considered when implementing an OPEB trust and establishing a reasonable funding policy to prefund OPEB.

Background on OPEB Funding

According to a 2019 Pew Trust study, US States had approximately $750 billion in OPEB liability with nearly $69 million of assets set aside to prefund the liability. This funded percentage of 9% was an increase from 2018 (8%) and 2006 (3%). The same 2019 study showed a majority of states still had funded levels below 30% and only 10 states had a contribution policy that met or exceeded the net amortization benchmark (contributions greater than the service cost plus interest on the net OPEB liability).

Case studies were presented from Vermont and California. Vermont is funding an actuarially determined contribution that is expected to fully fund OPEB by 2048. California's bargaining units began ramping up contributions in 2016 with a goal of contributing 100% of the normal cost, split equally between employee and employer.

The GASB (public sector) and FASB (private sector) standards related to OPEB may have led many to think more about prefunding OPEB. Particularly for public sector entities, the GASBS 74 and GASBS 75 standards required the full net OPEB liability to appear on the financial statement balance sheet.

Actuarial Basis for OPEB Prefunding

Prefunding models sometimes include the "unspeakable" (i.e., non-actuarially-based funding policies) where a single deposit is made up front then nothing thereafter, or "whatever they can afford" with small deposits, or a "willy-nilly" funding policy. It is important to consider a funding policy based on an adopted formula where substantial amounts are deposited, similar to a fixed-rate plan. Ideally, a consultant should lead a client toward an actuarially-based funding policy assuming the client has implemented an OPEB trust fund or are considering pre-funding. One question to ask is why they want to pre-fund or why they decided to pre-fund back when the trust was formed.

There are many leading questions to ask when considering prefunding OPEB, including "Why?". For example, is it important (a) that plan members can count on a reserve backing the OPEB promise (b) to

meet the OPEB obligation by systematically funding, and/or (c) to have a written prefunding policy, (d) to use a higher discount rate that is a result of prefunding OPEB based on a formal funding policy?

Resources available to the OPEB actuary include the GASB implementation guide and ASOP 6. Currently in progress is an update to ASOP 6 that will include changes similar to those recently adopted in ASOP 4 as well as a major Academy Practice Note on OPEB prefunding in the public sector.

OPEB Funding Policy

There are best practices in developing a formal funding policy that is compliant with statutes, GASB standards and/or ASOPs. It is recommended to include in the funding policy funding objectives similar to those outlined in the CCA White Paper 2.0 for pensions. The trust should operate like a pension trust – all contributions go into the trust and all benefits paid out of the trust. Operating the trust like a split-funded plan is not as clean and simple as one would expect (e.g. where some or no contributions go into the trust and benefit payments are not paid out of the trust). It is also recommended to include in the funding policy how contributions are developed and how and when benefits will be paid out of the trust.

Cross-Over Testing

The GASB OPEB standards require that the discount rate be based on a long-term rate of return expected to be earned by the OPEB trust to the extent assets are available to fund expected benefits. Once trust assets are depleted, a high-quality municipal bond rate is used to discount benefit payments. An OPEB plan with a reasonable funding policy generally will generate no 'cross-over date' because it anticipates that future contributions will be sufficient to fund all future benefits. A non-actuarially-based funding policy will likely require an open group forecast to determine if and when there is a cross-over date since the GASB rules require new entrants to have "first claim" on future contributions leaving the rest to accumulate the net fiduciary position.

Advantages & Disadvantages of OPEB Prefunding

There are many advantages to prefunding an OPEB trust, including the use of investment income to pay benefits, manage inflationary risks, stabilize employer contributions and allow the use of a higher discount rate that will lower the disclosed liability. Furthermore, prefunding may have a positive effect on bond ratings and garner more good will from plan members.

However, there are disadvantages to prefunding OPEB as well. OPEB plans will require high initial employer contributions and more complex administration. Contributions to the plan are irrevocable and may only be used to fund OPEB, requiring the plan sponsor to properly manage surplus when the program becomes fully funded. Actuarially determined contributions can be volatile due to the nature of the benefits, investment returns and assumptions. There may be less flexibility to amend or preserve benefits and policies. Finally, if employee contributions are required, they may be forfeited upon the employee's termination.

OPEB Prefunding Compared to Pension Prefunding

There are issues to consider when prefunding OPEB that generally do not arise when prefunding pensions. First, while pension benefits are strictly defined upon retirement, OPEB benefits are more volatile due to the uncertainty of healthcare costs, legislation and more frequent changes to plan structure or cost

sharing. The OPEB actuarially determined contribution (ADC) is correlated with all medical costs and can lead to volatile contributions due to volatile benefits. Second, while pension benefits are generally steady over time or increasing with the cost of living adjustments, OPEB benefits can vary greatly by plan design for pre-65, Medicare, caps or duration limits and the back-loaded nature of the expected benefits due to trend. Finally, pension trust assets generally start to build at plan inception and are well-defined by statute whereas OPEB trust prefunding may not have started until the plan was mature. Actual contributions to the OPEB trust would be an ADC in excess of the pay-as-you-go costs.

Conclusion

While it was noted that there are several disadvantages to prefunding an OPEB plan, there are many financial and non-financial advantages. Both should be weighed in the decision of whether an entity should prefund or not. "To Fund or Not To Fund", that is the question.

Session 608

Multiemployer Workshop and Hot Topics

Speakers:

- Heather Ray, FCA, ASA, EA, MAAA – Horizon Actuarial Services
- Jay K. Egelberg, FCA, ASA, MAAA, EA – First Actuarial Consulting, Inc. [FACT]
- Nadine Solntseva, FCA, MAAA, EA – First Actuarial Consulting, Inc. [FACT]

Session Host: Craig Voelker, FSA, EA – O'Sullivan Associates

Background

In this workshop the speakers served up hot topics within the multiemployer market. They provided a potpourri of current issues and outlooks and inspired a lot of lively audience participation related to the following topics:

- Pension-risk transfer
- Handling declines in coverage of active participants
- How to behave for an upcoming mass withdrawal
- Post-SFA plan operations
- Withdrawal-liability exemptions in certain industries
- Interest under ERISA sections 4213 and 4219
- Actuarial equivalence
- Chevron Doctrine: What to Expect

Pension-risk transfer

Mr. Egelberg began with Pension Risk Transfer (PRT). He described some of his experiences and compared the dynamics of PRT in a multiemployer vs. single-employer context, including the pros and cons. Some compelling statistics from the Life Insurance Marketing and Research Association (LIMRA) showed just how prevalent PRT has been recently due to the shifting interest rates environment. He discussed the litigious landscape, including the credit rating of insurance carriers, fiduciary duty, state guarantee associations, and several lawsuits.

Handling declines in coverage of active participants

Ms. Solntseva discussed declines in coverage of active participants. She reviewed a study by PBGC covering a 20-year period and offered insights. The baby boom and demographic trends were included. She cited that the average ages and entry ages are both trending higher and discussed the effect on costs. There was widespread agreement that apprentice programs had suffered during the Great Recession.

The audience related the decline in actives is also driven by withdrawing employers. There was much dialog related to this, including: funding relief, how to attract new employers, the Canadian system, plan design and maturity-neutral systems.

How to prepare for an upcoming mass withdrawal

The session segued to mass withdrawals and Mr. Egelberg discussed the statute and its many grey areas, including the meaning of "substantially all." He had also provided in this deck of slides a list of the many tasks and notifications, with their respective deadlines, required of trustee/plan sponsors once a mass withdrawal has been declared, but, in the interest of time, he did not enumerate each of these tasks but rather pointed out to the attendees that it was now intended as a reference guide should they encounter this situation in the future.

Post-SFA plan operations

Ms. Solntseva then discussed post-Special Financial Assistance (SFA) operations, including breaking developments on death audits and using Social Security's Master Death files and private options. She then discussed 5500 reporting and when and when not to include the SFA assets. She discussed funding method gains resulting from paying benefits out of SFA assets. Lastly, she discussed the need to keep two sets of books for Schedule H and Schedule MB reporting.

Withdrawal-liability exemptions in certain industries

Ms. Ray discussed Withdrawal Liability exemptions. She observed that fab shops are not eligible for the construction trade exemption and how that creates issues when, a short time ago, the same employer was not a fab shop and eligible for the exemption. The 85% rule was discussed, and the panel agreed that we didn't know what 85% was applied to. There was discussion on whose onus it is to prove a construction industry employer – the plan's or the employer's. Most agreed that the onus is on the employer.

With the theme of improving the multiemployer funding rules, Ms. Ray mentioned alternative rules, including the hypothetical of broadening the exemptions.

Interest under ERISA sections 4213 and 4219

Mr. Egelberg then discussed the interest rate assumption used in the determination of withdrawal liability and the historical litigation environment related to it.

Actuarial equivalence

Then Ms. Ray gave some history on plans' typical definitions of actuarial equivalence and how a change always ran the risk of being an impermissible cutback. She made the point that this is a plan document/Trustee issue and not within the purview of the actuary's assumption. She reviewed the recent flurry of litigation around this issue. And, while more prevalent with single-employer plans, there has been at least one multiemployer plan lawsuit. Lastly, she discussed a recent regulation that allows for "…more accurate or more appropriate…" definitions but that nothing is requiring plans to change their definitions.

Chevron Doctrine: What to Expect

There was widespread agreement that more lawsuits would result.

Session 703

Fiduciary Considerations in Annuity Placements

Speakers:

- Grace Lattyak, FCA, FSA, EA, MAAA – Aon
- James Walton, FSA – Agilis
- Tonya Manning, FCA, MAAA, FSA, EA – Gallagher
- William Ryan – Newport Trust Company

Moderator: John Malcolm Merrill, FCA, FSA, EA – Nicolay Consulting

Session Host: Tristan T. Christ, FCA, FSA, EA – WTW

Summary

As annuity placements from pension plans have continued to increase in both frequency and size, actuaries must be prepared to guide plan sponsors to appropriate resources so they can follow the best fiduciary processes possible. The panel provides a sweeping overview of the background and considerations for annuity purchases from ERISA-covered pension plans, including the history of fiduciary guidance, current legal and regulatory landscape, and fiduciary considerations and best practices.

Roles and responsibilities

A successful transaction will likely involve multiple parties with specialized knowledge, as annuity placements are not typically a regular nor ongoing occurrence for most plan sponsors. Transaction specialists (sometimes referred to as brokers) provide overall project management and coordination of the bidding process with insurers. Legal counsel advises on the overall structure of the annuity placement and the governance process to ensure the decision is well documented and avoids conflicts of interest. Independent Experts are a role specified in Department of Labor guidance and offer professional opinions on the financial strength of the bidding insurance carriers as well as other considerations such as participant experience and administrative capabilities. Finally, independent fiduciaries may also be involved if the plan sponsor lacks the requisite knowledge and skill necessary to fully carry out its responsibilities and/or wishes to ensure complete avoidance of any conflict of interest. The larger or more complex the transaction, the higher the likelihood an independent fiduciary may be involved.

How we got here

ERISA separately defines the roles of settlor (directing creation, amendment or termination of a plan) and fiduciary (those with financial or administrative responsibility for the plan). It also defines "party in interest", which covers essentially all service providers to the plan, some of which are fiduciaries (such as the plan trustees). Though not defined in ERISA, over time, the Department of Labor (DOL) has codified the concept of an Independent Fiduciary in regulation.

The failure of Executive Life prompted a call for guidance from the Department of Labor – which resulted in the issuance of Interpretive Bulletin 95-1 (IB 95-1). This guidance is short and principles-based, providing a blueprint for fiduciaries to make sound decisions in the selection of an annuity provider.

In 2012, Verizon settled a very large group of retirees with an annuity placement. This transaction gave rise to lawsuits and brought the issue back into more active discussion within regulatory agencies, though nothing had emerged until the passage of SECURE 2.0.

Current landscape

SECURE 2.0 required the DOL to review IB 95-1, consult with the ERISA Advisory Council (EAC), and report back to Congress on its findings. The DOL specifically raised 15 issues, chief of which were ownership structure, asset holdings, liability composition and reinsurance, but many other non-financial issues as well. Throughout 2023, the EAC received input from a variety of stakeholders and provided their conclusions to the DOL. There was no unanimous decision reached by the EAC, with 6 members recommending no change and 9 recommending some degree of change. These recommendations included consideration of administrative capabilities and updates to required notifications and clarification of requirements relative to spousal benefits and annuity benefits. The DOL received this input and then released its own report to Congress, which reaffirmed IB 95-1 but left the door open to further review and revision without outlining a specific timeline.

Also, during 2024, a series of lawsuits have been filed against plan sponsors who selected Athene as their annuity provider due to its capital and ownership structure.

Independent experts now more important than ever

The continued evolution of available investments, ownership structures and changes in reinsurance approach can put even financially savvy fiduciaries out of their depth. Independent Experts bring insights to the plan fiduciaries (whether Independent Fiduciary or the plan sponsor) regarding financial strength and exposures, potentially using stress testing or other mechanisms to tease out more about the relative stability of an insurer than simple balance sheet or capital disclosures can provide. Additionally, many of these experts also assess the administrative capabilities and other non-financial considerations. They also can assess the added degree of financial security provided by different deal structures using separate accounts and/or split-insurer placements.

Part of that participant protection assessment includes the degree of participant protection involved. Those benefits are backed by the pool of assets in a separate account (if applicable) as well as the general assets of the insurer. If the insurer's financial condition deteriorates to the point that regulators step in, then the full benefits are no longer guaranteed, however they may recover more of their benefit than the asset may have provided on their own through State Guaranty Association (SGA) coverage.

Each state has its own SGA coverage limits, with the state of residence of the annuitant governing the SGA coverage. The benefit guarantee applies to the present value of the benefits owed (not the annuity amount, as with a PBGC-covered pension plan benefit). These benefits apply for each life

that is covered under the annuity contract, such that a joint form of payment would have a separate guarantee for the primary annuitant and beneficiary.